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ABSTRACT

This study documents gaps in the way in which Medicaid meets its responsibilities to provide access to health care for children and offers recommendations on what should be done about the gaps. Major findings of the study are presented in a section on problems of eligibility, benefits, and reimbursement. Findings indicate that due to the inadequacies of Medicaid eligibility, almost half of all poor children do not have Medicaid and are in danger of falling through the Medicaid safety net. Many eligible children do not receive benefits to which they are entitled because the application process is too difficult to complete. Providers, such as children's hospitals, have incurred large financial losses and face difficulties in providing access to all children and in meeting their health care needs. It is concluded that the Medicaid safety net is in need of major repair. Recommendations propose the reform of Medicaid eligibility, enrollment, benefits, and reimbursement for children so that equal access to care for all children will be insured. It is expected that the reforms will be phased into the Medicaid program, thus complementing reforms which are needed to enhance the effectiveness of private insurance as the mainstream financing source. (RH)

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Assuring Children's Access to Health Care

Fixing the Medicaid Safety Net

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ASSURING CHILDREN'S ACCESS TO HEALTH CARE: FIXING THE MEDICAID SAFETY NET

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Assuring Children's Access to Health Care: Fixing the Medicaid Safety Net

October 1989

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"...the future of a civilization
may be judged by how it
cares for its young."

Daniel Patrick Moynihan

Chapter I

Executive Summary

Overview

Medicaid is this nation's health care safety net. It is intended to provide access to health care for the poor and for others facing medical indigence. The Medicaid program was designed to assist poor children and their families, the disabled poor, and the elderly poor to access health care. Eligibility for Medicaid was initially restricted to those eligible for cash assistance (i.e., welfare) and, at state option, those who would be eligible if their medical bills were subtracted from their income (the "medically needy").

This report documents the gaps in how Medicaid meets its responsibilities to provide access to health care for children and what should be done about these gaps. That major gaps exist in the publicly funded health care safety net for poor children is a reflection of a broader problem -- the lack of a clear national health policy. Although this report addresses only the Medicaid program and the needs of children, it is important to point out the need for a national health policy aimed at preserving and strengthening the private system of health care financing, which is currently the mainstay of access to care. The public Medicaid program should fill the gaps in the private health care financing system for children -- but it can do so only if the private system is strong and stable.

The available evidence is clear - the Medicaid safety net for children is in need of major repair:

- Due to the inadequacies of Medicaid eligibility, almost half of all poor children do not have Medicaid and are in danger of falling through the safety net. As of January 1989, eligibility criteria for Medicaid for most children in most states was contingent on virtual destitution.
- Many children who are eligible for Medicaid do not receive benefits to which they are entitled because the application process is too difficult to complete.
- Many children who do receive benefits do not have access to the services they need because of arbitrary restrictions on covered services, services which are not covered at all, and difficulties in finding providers who are willing to accept Medicaid's inadequate payments.
- Providers such as children's hospitals, which are committed to serving Medicaid children, have incurred large financial losses in the past and face difficulties in providing access to all children and meeting all their health care needs. Approximately 25 cents of every dollar of cost (not charges) which children's hospitals spent on treating Medicaid children went unpaid by Medicaid in 1987. As a result, children's hospitals must look elsewhere to recover their costs. In today's competitive health care environment, funds to support such losses may not always be available.

Most of these problems are readily solvable. This nation has made a commitment to assure health care access for our other major vulnerable populations, the elderly, and the permanently disabled. It is now time to make a similar commitment to assure access for all of the poor and near poor children who lack financial access to care. The future economic well-being of the country is dependent on the current generation of children growing up to be healthy and productive adults. An improved Medicaid program is an investment in children's health and in the future of the U.S.

The major objectives of this report are to:

1. Identify how the Medicaid program is intended to assure children's access to health care.
2. Document gaps and problems in Medicaid eligibility and service coverage for children.
3. Report on the extent of Medicaid payment shortfalls in children's hospitals and describe how these are likely to affect children's access to care.
4. Propose policy options for reforming and improving the Medicaid program for children.

The report does not attempt to evaluate which states have better or worse programs. There are serious deficiencies in every state, even those programs which been viewed as models.

This report draws from a variety of public and private data sources and independent studies. It also includes two new major study efforts:

- A special 1988 survey conducted by NACHRI on the impact of Medicaid policies on children's hospitals and their service to Medicaid children, including an analysis of hospitals' FY 1987 Medicaid costs and reimbursement. The results from this survey and analysis are presented for the first time in this report.
- An independent assessment of the gaps in Medicaid eligibility and service coverage conducted by the Intergovernmental Health Policy Project of George Washington University at the request of NACHRI. The results from this study were first published in a September 1988 report entitled, "Medicaid and Poor Children: State Variations in Eligibility and Service Coverage," and have been incorporated into the text of this report as well.

The major findings of the study are summarized below along with our recommendations.

A. Summary of Eligibility, Benefit, and Reimbursement Problems

Medicaid is a state-operated program jointly funded by the federal and state governments. Its complexity and wide range of state options result in many inequities regarding which children are served and the services to which they have access.

In large measure, these problems reflect the fact that Medicaid eligibility for children has historically been tied to eligibility for AFDC -- welfare assistance to families with "dependent" children (i.e., children with one or both parents absent). Children who qualify for AFDC automatically qualify for Medicaid. Because states set the income limits for AFDC, children who qualify for Medicaid in one state may not be eligible in an adjoining state. Because some states have not elected certain options, many children in these states with incomes below the AFDC level are excluded from Medicaid simply because they live in a two-parent family.

States can elect to provide Medicaid to medically needy families -- those with incomes above the AFDC level who need assistance to meet uninsured medical expenses -- but some states have declined.

The most significant specific problems affecting eligibility are:

- Basic Medicaid eligibility for children is based on the income limit for AFDC welfare eligibility which varies from state-to-state and averaged only $399.25 per month for a family of 3 as of

January 1989 (see Chapter III). This amount is only 47 percent of the federal poverty level of $10,060 per year for a three person family. In Alabama, income in excess of $118 per month for a three person family disqualifies children from Medicaid, as does income in excess of $184 per month in Texas, $218 in Arkansas, and $218 in Kentucky (see Chapter III).

- Only 36 states offer the optional medically needy program (see Chapter III). This option allows additional, poor and inadequately insured children to receive Medicaid. The program is of limited effectiveness because:
    - the average state-set medically needy income eligibility limit was only 60 percent of the federal poverty line (as of January 1989). Some states might wish to set higher limits, but federal law caps medically needy eligibility at 133 percent of the state's AFDC income limit.
    - inadequately insured children with higher incomes can qualify, but only by incurring medical bills which render the family destitute. Medically needy eligibility for these children is established by paying or incurring medical bills which reduce income to the medically needy income limit, a process referred to as "spend-down." Families must spend-down to medically needy income limits which are below the federal poverty line in all but two states as of January 1989.
    - many medically needy patients do not or cannot pay their spend-down obligations, making providers reluctant to accept them and thus limiting access.
- In 1986 and 1987, Congress began severing the Medicaid link to AFDC income and dependency criteria by giving states the option to offer Medicaid to children in all types of families with incomes below the federal poverty line -- but only up through age seven (see Chapter IV). As of July 1989, 45 states elected to provide optional coverage -- but seven limited it to children under age one and 19 limited coverage to children under age four. The legislation also allows states to offer Medicaid to pregnant women and infants up to age one with incomes below 185 percent of the federal poverty line.
- In 1988 Congress continued the de-linking of Medicaid from welfare by mandating Medicaid eligibility for all pregnant women and infants up to age one with incomes below the federal poverty line and by extending eligibility to include all children in two-parent unemployed families with incomes low enough to meet state-set AFDC requirements.
- The application process is a major barrier, with forms and documentation requirements so complex and lengthy that (according to data reported in a national study of official data) one-quarter of applicants are found ineligible, not because of income or assets in excess of limits, but because they could not complete the process (see Chapter IV).
- Many hospitalized, severely disabled and technology-dependent children, who can be cared for appropriately at home, cannot be discharged because they will lose their Medicaid eligibility (under a special rule for the institutionalized disabled) if discharged -- and their families cannot afford care at home without Medicaid (see Chapter III).

As a result of the inadequacy of Medicaid eligibility, an estimated 32.8 percent of all poor children in the U.S. had no source of health care financing in 1986 and the 15.3 percent of poor children who had private insurance were in jeopardy because of rapidly declining employer-provided coverage for this group.

Although both children and the elderly are vulnerable groups in need of protection, there are major inequities between the eligibility criteria for and resources devoted to children and those devoted to the elderly. The commitments this country has made in assuring basic health care for the elderly are laudable; they serve as a guide to the improvements which should be made on behalf of needy children.

- Under the 1988 Medicare Catastrophic Coverage Act, state Medicaid programs must serve all elderly persons with incomes below the federally-defined poverty level (by providing, at a minimum, payment for the Medicare Part B premium and Medicare copayments and deductibles). For children below the poverty line, the new law requires states to serve only infants up to age one. States can elect to serve other poor children above the AFDC welfare income level -- but only up through age seven. In addition, the elderly are allowed several times the assets permitted a child's family.

- Children (under age 21) comprise 50 percent of all Medicaid beneficiaries but account for only 20 percent of Medicaid expenditures, while the elderly make up 16 percent of the Medicaid population, but use 39 percent of the resources (see Chapter IV).

- Medicaid spending per child (in constant dollars) decreased from 1978 to 1984 by 14.4 percent, while Medicaid spending per elderly recipient increased by 28.8 percent (see Chapter IV).

Many Medicaid programs have benefit restrictions, limitations, and exclusions (see Chapter III). These are bigger barriers to children's access than they are for the elderly and disabled, because poor children must rely on Medicaid alone, while the elderly and many of the disabled have Medicare as their primary means of access. As examples:

- Ten states limit hospital stays by children and adults. Alabama allows only 12 days per stay and Louisiana permits only 15 days.

- Eleven states limit the number of hospital outpatient visits or annual payments. Alabama allows only three visits per year; Idaho and Mississippi allow only six per year.

Greater uniformity in eligibility criteria and health care benefits for children, particularly those with chronic or disabling conditions, would contribute to a more effective and equitable program.

Providers with a disproportionate share of Medicaid, charity, and other inadequately insured patients are particularly vulnerable to Medicaid payment shortfalls and low fee schedules (see Chapter V). It increases their need to raise additional revenue from charge-paying patients at the same time it decreases the number of charge-paying patients. It also limits their financial ability to offer the very services upon which the Medicaid and uncompensated patients are dependent for access. The problems of low Medicaid payment levels and disproportionate share affect hospital and non-hospital care providers.

- Children's hospitals are major disproportionate share providers (see Chapter V):
    - Medicaid patients comprise over 20 percent of the inpatient days in 73 percent of acute care children's hospitals, while this level of service to Medicaid patients is reached in less than 10 percent of private non-profit hospitals.
    - Children's hospitals devote 8.0 percent of their services to charity and bad debt patients compared to 6.4 percent for all hospitals.

- Children's hospitals were almost universally undercompensated by Medicaid for the services provided to children enrolled in the Medicaid program in 1987 (see Chapter VI):
    - Medicaid payment fell far short of the financial requirements of most children's hospitals: for 89 percent of children's hospitals, Medicaid payments did not even reach 95 percent of costs (not charges); for 47 percent, Medicaid paid less than 80 percent of the cost of serving Medicaid patients.
    - In the average children's hospital, Medicaid losses totaled 25 to 26 percent of the cost of serving the Medicaid population.
- Three factors account for the children's hospitals' losses of 25 cents per dollar of cost to serve Medicaid children (see Chapter VI for quantitative analysis and Chapters VII-IX for qualitative analysis):
    - Inadequate reimbursement rates paid for Medicaid covered services produced an average loss of 16 cents per dollar of cost incurred by the children's hospitals in treating Medicaid children.
    - Medicaid uncovered services due to limits on the amount of covered care (eg., covering only 12 days per hospital stay or only 3 outpatient visits per year) and excluded services (eg., not covering outpatient physical therapy) accounted for an average loss of 6 cents per dollar of cost for the care provided to these children.
    - Services provided to children who were eligible for Medicaid but not enrolled in Medicaid amounted to additional losses of 3 - 4 cents per dollar of cost. Because children's hospitals found it difficult to account for the losses due to enrollment problems, this loss and the total Medicaid loss are probably under-estimated.
- Children's hospitals help children and families to enroll in Medicaid. One-third support on-site Medicaid enrollment and many more would like to do so. Nonetheless, four-fifths cited enrollment difficulties as a financial problem (see Chapter VII).
- Payment delays and disputes were cited as problems by almost all the children's hospitals. More than half the hospitals averaged a quarter of a year's Medicaid billings (i.e., three months worth) in accounts receivables at any one time (see Chapter X).
- Because of concentrated Medicaid losses, a quarter of the children's hospitals reported they have been unable to add or expand certain affected services or are considering curtailing selected services (see Chapters VIII and IX). Outpatient services are most in jeopardy.
- Low Medicaid payment rates for physicians are widely acknowledged by Medicaid analysts as a major barrier to office-based care for children and pregnant women. Almost one-quarter of the states (23%) pay less than half of the amount Medicare allows for a typical office visit (see Chapter III).
- Children's hospitals were virtually unanimous in noting that low Medicaid fees are a problem for both primary care physicians and specialty pediatric physicians and that low fees make it difficult for children to gain access to non-hospital based physicians (see Chapter XII).

- Medicaid children who are hospitalized in general hospitals and children's hospitals appear to be more severely ill than other hospitalized children -- they have longer average stays, a higher proportion of exceptionally long stays, and more frequent catastrophic stays. Medicaid children with congenital, chronic, and other conditions requiring specialized care are concentrated in children's hospitals and teaching general hospitals. Because children's hospitals and teaching hospitals serve a higher proportion of extremely sick, long staying, costly, and catastrophically ill Medicaid children, they face a systematic financial risk (see Chapter V).

Maintenance of effort is a concern as the Congress provides new options and mandates for Medicaid eligibility, service coverage, and payments, and as states elect to expand eligibility. Both state officials and hospitals have been increasingly concerned about the commitment of adequate state funds to maintain the current levels of services and reimbursement. In several states it appears that reimbursement rates are likely to be reduced in order to pay for eligibility expansions. Oregon has been considering how to ration services in order to pay for eligibility expansions and New York has moved to limit the numbers of physician visits and prescriptions allowed.

While responsibility for adequate funding of Medicaid is largely a state matter, the federal government has used little of its oversight authority to ensure that states maintain an adequate level of service benefits and set payment rates which meet federal requirements for ensuring access to care and meeting the costs of efficiently operated hospitals. HCFA has not established procedures to determine if state-set hospital rates comply with federal law requiring adequate payments to hospitals and nursing homes.

B. Summary of Report Recommendations

The report proposes to reform Medicaid eligibility, enrollment, benefits, and reimbursement for children to ensure equal access to care for all children, including those who are not adequately insured. The broad set of reforms proposed in the report's recommendations are intended to be comprehensive and to fill the gaps in private financing of health care for children. It is expected that these reforms will be phased into the current Medicaid program, complementing reforms which are needed to enhance the effectiveness of private insurance as the mainstream financing source. The proposed Medicaid reforms are presented in detail in Chapter XIII and include:

1. Establishing More Uniform Eligibility for Children; De-linking from Welfare; and Facilitating Enrollment

- Raising eligibility for all children (and pregnant women) in all states to 185 percent of poverty, plus allowing states to permit those with higher incomes to buy into Medicaid and allowing states to purchase employer-offered insurance for the eligible working poor. This recommendation builds on the Medicaid option enacted in December 1987 which allows states to set eligibility at 185 percent of the federal poverty line for pregnant women and infants under one year of age and to charge nominal premiums for those with incomes over 150 percent of poverty (i.e., Medicaid buy-in), and the 1988 welfare reform act option which allows state Medicaid programs to purchase employment-based insurance for AFDC beneficiaries making the transition to paid employment. It also complements proposals, which NACHRI supports, to improve private insurance coverage through tax credits, mandates, and/or other mechanisms.

- Requiring all states to offer medically needy programs and preventing medical destitution by limiting the spend-down obligations of the medically needy to a reasonable percent of income.

- Eliminating asset tests for poor children and liberalizing them for the near poor and medically needy.
- Establishing special expanded eligibility for technology-dependent and chronically ill children.
- Facilitating Medicaid enrollment and speeding access to care through presumptive eligibility and streamlined processing, as is an option under the 1987 eligibility expansions for pregnant women.

2. Establishing More Uniform and Broader Service Packages for Children

- Expanding required benefits for all eligible children.
- Enhancing services to meet special needs of technology-dependent and chronically ill children.
- Phasing-out of limits on essential services, beginning with elimination of inpatient stay limits for disproportionate share providers.

3. Ensuring Adequate Reimbursement

- Strengthening disproportionate share payment requirements by relating payment levels to hospitals' financial requirements as part of a broader enforcement of adequate payment standards for all hospitals.
- Expanding and enforcing implementation of requirements for adequate payment of exceptionally long and costly inpatient stays.
- Expanding disproportionate share payments to outpatient care.
- Establishing prompt payment requirements.
- Requiring equitable payments to out-of-state hospitals.
- Requiring states to set adequate physician payment in order to ensure access to care.
- Expanding the disproportionate share concept to non-hospital providers of primary pediatric care (eg., pediatricians, family practitioners, nurse practitioners, neighborhood health centers, etc.), pediatric specialists, and obstetric care physicians.
- Developing and implementing payment methods which recognize the differences in the patient mix and care provided by community hospitals and specialized pediatric providers.

4. Commitment to Adequate Resources

- Ensuring current benefits and reimbursement levels are maintained or improved while eligibility is expanded.
- Enhanced federal matching rates could be used to ease the burden and ensure maintenance of current benefits and reimbursement levels in those states which shoulder the largest increases in implementing mandated and other improvements in eligibility, benefits, and access.

- Extending the formal federal legislative authority for voluntary contributions. This can serve as a stopgap measure when inadequate funds have been appropriated by a state.

The proposed reforms (not including expansions of medically needy eligibility) would cost an estimated $10 billion in federal and state dollars, and would add coverage for 7.5 million of the 11 million uninsured children (amounts reflect 1986 data). The real net cost to society may be one-third or less of the direct Medicaid costs to the federal and state governments because of offsets to existing uncompensated care and out-of-pocket costs. In addition to covering more than half of the uninsured children, the reforms would safeguard access for the 10 million children now served by Medicaid. Many of the reform elements are being advocated by other groups and have been introduced as legislation in the 101st Congress.

It should be understood that Medicaid reform is dependent on maintaining an appropriate mix of public and private financing of care. Medicaid can afford to fill the gaps in private health care insurance only under a system which assures - through mandates and incentives - that the present level of private health financing is maintained or improved. Individuals and employers would gain by reducing or eliminating health insurance coverage and using Medicaid instead. In other words, filling the gaps in private coverage means limiting the size of the gap in the first place. Medicaid reform should build on the principle that Medicaid is the payer of last resort and that Medicaid reform should be accompanied by private sector reforms.

Chapter II

Introduction and Study Methods

The Medicaid program is much in need of a major reform if it is to fulfill its promise as the health care component of this Nation's social safety net for children. It is the ultimate purpose of this report to provide a vision of the steps which can be taken to transform the current program into a truly effective means of assuring that no child in America goes without needed health care, to assure that no child falls into the gap between private health insurance, the mainstay of access to care for the majority, and Medicaid.

The fact that such a study emerges from the nation's children's hospitals should not come as a surprise. While only nine percent of all children are treated in children's hospitals, these hospitals have long served as a microcosm for viewing the broader world of pediatric care. Because of their unique focus, children's hospitals are often able to identify emerging trends and problems associated with the health of children. For example, it was in a children's hospital that the phenomenon of pediatric AIDS was first identified; it was in a children's hospital that the national tragedy of child abuse was first articulated.

Because of their role as regional referral centers for very ill children, children's hospitals are more likely to inherit the victims of ill-advised public policies and to make a collective assessment of newly developing problems. The child who was never immunized against pertussis, the AIDS baby, the low birth weight newborn with extensive problems -- these children are routinely referred to our hospitals for specialized care. As these cases mount and information is exchanged across hospitals, new evidence can be compiled to identify policy-related health problems that may eventually affect children in other institutional health settings. Children's hospitals are, therefore, ideally situated to observe our society's failure to deliver preventive services and to provide ready access to care for sick children.

This singular focus on children offers us a unique perspective on Medicaid as well. While most hospitals struggle with Medicare reimbursement, Medicaid is the largest single payor of care in children's hospitals. NACHRI is, therefore, uniquely positioned to assess Medicaid's adequacy as a social safety net for children and their families.

Over the past decade, NACHRI and its member hospitals observed that, in some states, there were major gaps in eligibility and significant limitations to the services covered by Medicaid. It became clear in comparing hospitals' experiences with families that these access problems and benefit limits posed significant barriers to the treatment of sick children.

NACHRI also observed that the capacity of the children's hospitals to care for children without health insurance was being eroded by large shortfalls in Medicaid payments, and saw the need to educate policymakers about the special situation of hospitals which are disproportionate share providers of care to the poor.

Finally, NACHRI observed that the growing threat of an AIDS epidemic had the potential to create a divisive tug-of-war for scarce resources between needy groups and wished to focus public attention on the necessity of allocating adequate resources to the health care of all the poor and needy.

Such an initiative is not without precedent. In the 25 years since Medicare and Medicaid were launched as part of this nation's war on poverty, significant progress has been made on several fronts. The elderly, once the poorest group of Americans, saw their poverty rate decline from 28.5 percent in 1966 to 12.4 percent in 1986. But, over this same period, children became the "new" poor, with almost 23 percent of all children five years old or younger now living in poverty.[1] Far from abandoning federal assistance as a tool for economic progress, we should draw inspiration from our success in combatting elderly poverty. If the promise of Medicaid is to be kept, as the promise of Medicare has been realized, it is time now to address the needs of children for access to quality health care.

In response to these observations, the 100 children's hospitals in the U.S. and Canada who are NACHRI's members decided to commit the Association's staff and resources to a year and a half long project to study these issues and compile a comprehensive report aimed at identifying the major problems and articulating solutions to fix the Medicaid health care safety net for children. This report is the result of that effort.

A. Purpose of Report

The four objectives of this report are to:

1. Describe how the Medicaid program is intended to assure children's access to health care and the basic design of the Medicaid program.
2. Document gaps and problems in Medicaid eligibility and service coverage for children.
3. Report the extent of Medicaid payment shortfalls in children's hospitals and describe how these are likely to affect children's access to care.
4. Propose policy options for reforming and improving the Medicaid program for children.

The roots of the Medicaid program began in the War on Poverty. The Medicaid authorizing legislation emerged in 1965 from the House Ways and Means Committee, almost without debate or notice, as the medical assistance companion to the very public and much debated Medicare program. This new Title XIX of the Social Security Act contained ample authority for states to develop and implement a major new program that could assure health care for all families, disabled adults, and senior citizens who lacked health insurance or had inadequate resources to bridge the gap between their health insurance coverage and their health needs. But the implementation of Medicaid as a component of the welfare cash assistance system and conflicting budget priorities quickly extinguished the flickering flame of the program's potential. Now, two decades later, the original vision is re-emerging in legislation that is gradually freeing the program of its welfare roots and re-focusing the program on one of its major goals: assuring access for those children in need of health care.

This report is intended to identify the gaps and needs in the context of the current Medicaid program and the populations of children in need of health care financing. Its recommendations are intended to provide a broad and comprehensive reform, as well as the incremental steps by which the Medicaid program can be transformed to meet the health care financing needs of children and assure their access to effective health care services.

These recommendations focus on the federal level because basic reforms are needed. However, the success of any federal efforts rests on the states. State choices are important even in advance of major federal changes in program design and options. For example, a portion of the improvements needed can be accomplished to some degree at the state level today. But some of the most important improvements that states may wish to make require new federal legislation. A few of the recommendations for federal action could possibly be rendered obsolete, but this would require all the states to elect to implement options which are now available -- an unlikely turn of events.

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[1] From 1959 to 1986, the poverty rate for the elderly declined from 35.2 percent to 12.4 percent. However, in 1986 21.3 percent of all children under age 15 were poor. Source: Michael Harrington, Robert Greenstein and Eleanor Norton, "Who Are the Poor? A Profile of the Changing Faces of Poverty in the United States in 1987," Justice for All, Washington, D.C., p. 8.

The report is not intended to catalogue the problems of individual states or to evaluate which states have better or worse Medicaid programs. There are serious deficiencies in every state, even those programs which are perceived as models. The report does identify areas where there are wide gaps and discrepancies across the states and illustrates the problems with some specific examples. The report also notes sources of detailed information which can be used to compare features of a state's Medicaid program with those of others. Thus, while the primary purpose of the report is to spur reform at the federal level, the report should also be used as a framework for assessing state programs, identifying options, and pursuing action.

B. Organization of Report

The majority of this report looks at Medicaid in terms of the children it serves (or should serve) as viewed from the special perspective of the children's hospitals. Because children's hospitals serve children almost exclusively and because they provide about one-third of their care to Medicaid and other children with inadequate health care financing (about three to five times the national average), the children's hospitals serve as a magnifying glass for projecting how well or poorly the Medicaid program meets children's needs throughout the health care system. Where there are problems for children in obtaining access to Medicaid, these problems are magnified several fold in the children's hospitals; where there are problems with Medicaid payment, they are so much more apparent in children's hospitals.

Most of the issues, problems, and solutions identified in the context of the children's hospitals are equally applicable to children, Medicaid, and hospitals in general. There are, however, a few issues and problems discussed in this report which are specific to the children's hospitals and to other disproportionate share providers.

Chapter III provides an overview description of how the Medicaid program works, which is intended to serve as the background for Chapter IV which lays out the problems and gaps in the Medicaid program.[2] These chapters are based on a study of Medicaid eligibility and service coverage by the Intergovernmental Health Policy Project of George Washington University, which was prepared for and published by NACHRI in September 1988, and a variety of other published studies and public documents.[3]

Chapter V illustrates the role of children's hospitals and other hospitals in serving Medicaid and other inadequately resourced children. It also introduces the special problems which face hospitals with a disproportionate share of these patients.

Chapter VI provides the results of an analysis of the financial impact of Medicaid payment on children's hospitals. It and the chapters which follow are based on a survey conducted by NACHRI in the fall of 1988. Chapters VII through XII describe the various aspects of Medicaid as they impact children and children's hospitals, including eligibility, service coverage, hospital inpatient and outpatient reimbursement methods, payment timeliness, and physician reimbursement.

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[2] Those readers who are very familiar with the Medicaid program and its options may wish to proceed directly to Chapter IV.

[3] Susan S. Laudicina and Debra J. Lipson, "Medicaid and Poor Children: State Variations in Eligibility and Service Coverage," NACHRI, Alexandria, Virginia, September 1988.

The final chapter, XIII, provides the recommendations for reform and improvements in the Medicaid program. Limited cost estimates are also provided.

The remainder of this section describes the sources of the information used in compiling this report.

C. Data Sources and Study Methods

This document draws on a variety of data sources, including published reports and studies conducted by NACHRI. The three studies conducted specifically for this report are described following a short review of general references sources for this report.

Specific citations are provided throughout the text. The general reference sources which proved particularly valuable in the preparation of this report are noted below.

Much of the descriptive information about the Medicaid program is based on information HCFA compiles and publishes and from federal legislation and regulations. The Congressional Research Service, an arm of the Congress, has recently compiled much of this information, along with its own analyses and references from the literature, into a single volume, 500 page, highly detailed document entitled, "Medicaid Source Book: Background Information and Analysis."[4] Extensive references throughout this report cite the Medicaid Source Book, rather than the original source documents and data because of its easier availability for readers who desire additional information.

Several exhibits displaying the current status of the Medicaid program were provided by the National Governors Association and the Children's Defense Fund and are reproduced with their permission.

The "Medicare - Medicaid Guide," published by Commerce Clearing House (Chicago, IL), is our reference source for case law and the legislative history of provisions of the Social Security Act.

An unpublished review of the recent history of the Medicaid program, written by Sara Rosenbaum of the Children's Defense Fund and read in its draft version, provided a useful perspective on how the Medicaid program has evolved and where it may be headed. The book "Medicaid: The Trade-off between Cost Containment and Access to Care," written by John F. Holahan and Joel W. Cohen of the Urban Institute, provided very useful information on how Medicaid legislation in the early 1980s has had very different impacts on the several populations served by Medicaid.[5]

The three studies conducted specifically for this report are described below.

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[4] Congressional Research Service, "Medicaid Source Book: Background Information and Analysis," U.S. Government Printing Office, Washington, D.C., November 1988. (For sale by the Superintendent of Documents, Congressional Sales Office, GPO, Washington, D.C. 20402, as: Committee Print 100-AA, 100th Congress 2nd Session. Price not specified.)

[5] John F. Holahan and Joel W. Cohen, "Medicaid: The Trade-off between Cost Containment and Access to Care," The Urban Institute Press, Washington, D.C., 1988.

1. Intergovernmental Health Policy Project Study

In the spring of 1988, NACHRI commissioned the Intergovernmental Health Policy Project of George Washington University (IHPP) to conduct an independent analysis and description of the gaps and state-to-state variations in the implementation of the Medicaid program. IHPP is a leading independent source of current information on state Medicaid policies and programs.

The report of this study was published by NACHRI in October 1988 under the title, "Medicaid and Poor Children: State Variations in Eligibility and Service Coverage." The report provides a detailed description of the Medicaid program and extensive tables giving the eligibility thresholds, services covered, and benefit limitations on a state-by-state basis. It also includes a case study analysis of how differently four real children seen in children's hospitals would have fared under the Medicaid programs in Texas, California, Ohio, and Alabama.

The "Medicaid and Poor Children" report was the primary source for the analysis of gaps and problems in Medicaid (Chapter IV) and major portions of the description of the Medicaid program (Chapter III).

2. NACHRI Survey of Medicaid Reimbursement of Children's Hospitals

The majority of this report (Chapters IV - XII) is based on a survey of the NACHRI member children's hospitals which was conducted in the fall and winter of 1988-89. The survey collected both financial information based on hospital FY 1987 audited financial reports and observations about the Medicaid program as of October 1988.

a. Survey Objectives

The primary objective of the NACHRI Medicaid Reimbursement Survey was to identify and quantify the nature and extent of problems in inadequate Medicaid reimbursement for the services children's hospitals deliver to Medicaid-eligible children and the effect these shortfalls may have on children's access to care. The survey was intended to look at the three policy components which in combination determine the adequacy of reimbursement to the hospital and children's access to care:

- Eligibility processing (enrolling eligible children in Medicaid so that they can access care and providers can be compensated).
- Service coverage gaps (uncovered services) and limits on services (inadequately covered services); and,
- Medicaid reimbursement methodology and payment rates (the amounts hospitals are paid for covered services provided to enrolled children);

b. Survey design

The survey was designed to capture both financial data about children's hospital's Medicaid and total costs, utilization, and payments and the hospital's views regarding the existence, severity, and nature of problems and favorable features of their state's Medicaid program. The initial draft of the financial survey was intended to fill a few gaps in the AHA annual survey dataset.

The study design and draft survey was reviewed by a Technical Advisory Committee consisting of four senior finance staff from four children's hospitals.[6] Based on the Technical Advisory Committee's recommendations, extensive modifications were made to the financial portion of the survey. Changes were also made to the questionnaire portion of the survey as well.

The final survey consisted of the following sections:

Part I. FINANCIAL REPORT

- Report 1: Patient Accounts Practices and Definitions
- Report 2: Hospital Utilization Statistics
- Report 3: Hospital Revenue and Expense Totals
- Worksheet A: Reclassification Adjustments to Medicaid Gross Revenues
- Worksheet B: Calculation of Medicaid Covered Charges
- Worksheet C: Reclassification Adjustments to Medicaid Net Revenues
- Worksheet D: Breakout of Charity and Bad Debt by Source
- Report 4: Hospital Patient Revenue Summary for Hospital Fiscal Year 1987

Part II. QUESTIONNAIRE

- A: Eligibility and Service Coverage Issues
- B: Medicaid Inpatient Payment Methodology (In-State)
- C: Medicaid Outpatient Payments (In-State)
- D: Prompt Medicaid Payment (In-State)
- E: Physician Reimbursement
- F: Out-of-State Medicaid Reimbursement
- G: Desirability of Potential Medicaid Reforms

Children's hospitals and pediatric units which were part of larger institutions ("joint hospitals") were asked to complete the survey and provide data only for the pediatric portion of their hospital.

The financial analysis portion of the survey was specifically designed to assist hospitals in reporting Medicaid and total patient charges, costs, and net revenues in a consistent manner. The survey also called on hospitals to remove from Medicaid gross revenues any charges that were the responsibility of another third party payor and to report Medicaid charges separately according to whether the charges were:

o Unpaid because the patient did not effectively enroll in Medicaid even though eligible or because the Medicaid ID number was not made available to the hospital (usually due to retroactive enrollment);

o Unpaid because the services were not covered by Medicaid, even though the patient was enrolled in Medicaid and had a valid ID (eg., uncovered and restricted services and utilization in excess of a limitation); or o Covered (not in one of the above categories), even if Medicaid payment was less than charges or costs.

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[6] The committee members were: Mark Splittgerber, Vice President of Finance, Cook-Ft. Worth Children's Hospital (Texas); Marty Epstein, Reimbursement Director, Children's National Medical Center (Washington. D.C.); Steven Miller, Director of Reimbursement, Minneapolis Children's Medical Center (Minnesota); and Christine Sarrico, Controller, Children's Hospital - Oakland (California).

This was necessary because of differing ways different hospitals define Medicaid gross revenue (charges). Some hospitals ordinarily include in Medicaid gross revenue the charges for patients whose eligibility is pending, while others keep these charges in a separate category or lump the pending eligibles in with other private pay patients. Also, where there are Medicaid patients with private payment obligations, as occurs with spend-downs and uncovered services, some hospitals keep these charges in their Medicaid gross revenue, while others report them as private pay bad debt or charity. The survey provided detailed worksheets to help the hospitals reclassify gross and net revenues into a standard format. It was suggested that samples from reimbursement logs or non-financial data, such as discharge abstracts, could be used to estimate the uncovered charges which were unpaid because of service benefit limitations or enrollment problems.

c. Survey Response and Editing

The survey was mailed to 90 NACHRI member children's hospitals in the United States on October 26th, 1988 with a request that it be returned by December 2nd 1988. In conjunction with the survey, three regional Medicaid Reimbursement Seminars were held in Alexandria, Virginia; St. Louis, Missouri; and San Francisco, California to assist hospitals with the completion of the survey by clarifying the objectives, definitions and uses of the data. Telephone consultations were also provided for respondents needing help with completing the survey. Letters and telephone calls were used to follow up with non-respondents.

Fifty-two surveys were received, edited and entered into a computer data base for analysis (see Appendix 1 for the list of hospitals surveyed and those responding). Of the 52 respondents, eight had incomplete or no financial data and five were joint hospitals which provided data that were not comparable because it included their entire adult patient populations. The surveys were extensively edited for consistency, mathematical accuracy, and to clarify unclear items. Numerous phone calls were made to clarify items and to be sure that the financial data were responsive to the definitions and that they excluded research and patient care professional services of physicians.[7] A summary of the key financial indicators was sent to each hospital for verification after the initial edits were completed.[8] This resulted in phone calls from about a half dozen hospitals volunteering mostly minor revisions, as well as resolution of most of the financial data which had serious problems. However, three hospitals' financial data had to be rejected because of unresolved problems.

The financial analysis uses data from only 36 of the responding hospitals: 32 freestanding acute care children's hospitals and four specialty care children's hospitals. None of the joint children's hospitals was able to provide data exclusively for pediatrics' financial analysis. However, some of the joint hospitals did provide usable utilization statistics for their pediatric patients. Other hospitals were excluded because they provided only partial data or did not pass edit checks.

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[7] Considerable attention was devoted to assuring that respondents provided patient care costs as defined by Medicaid principles, since some hospitals interpreted this to mean direct costs and others initially supplied total hospital operating costs. Likewise, if professional physician costs or revenues were included, efforts were made to remove them or, in a very few cases, to ensure that they were consistently included in all financial data.

[8] The data verification was also provided to hospitals whose data did not pass edits as a means of bringing the data anomalies to their attention. These hospitals also received follow-up telephone calls.

From the questions asked about accounting conventions and from the notations on the worksheets and attachments, it was clear that all of the 36 hospitals provided acceptable information on covered charges for Medicaid patients.[9] Most of the hospitals were able to calculate or estimate the charges on uncovered services provided to children enrolled in Medicaid. However, even though the majority of hospitals responded on the questionnaire portion of the survey that they had major or minor financial problems due to difficulties eligibles had with enrolling (and staying enrolled) in Medicaid, only a quarter were able to report the charges for this group.

d. Representativeness of Respondents

Representativeness of the survey respondents can be viewed in terms of whether the respondents represent the full set of hospitals surveyed and whether there are enough hospitals to reflect the variations across the states and regions of the U.S.

In terms of states and regions, the respondents reasonably represent the four regions, although the West, with six respondents, is under-represented compared to the other three regions with 12 or more each. The 90 hospitals surveyed were distributed across 29 states. Of these, there are 21 states represented in the analysis. Most of the missing states have small Medicaid and total populations. Thus, the survey responses can present a representative picture of Medicaid, even though not all states are included.

In terms of the three different types of children's hospitals, the survey garnered excellent response from the freestanding acute care children's hospitals: 84.1 percent responded (see Exhibit II-1). Although half of the freestanding acute care children's hospitals which did not respond were in the West, there are as many from respondents from this region as from the Northeast, where all six freestanding acute care children's hospitals did respond.

Forty percent of the 15 specialty care children's hospitals responded. One of the non-respondents noted that the hospital had just begun to accept Medicaid reimbursement and did not have enough experience on which to provide valid information. Since these are smaller hospitals with patients who often have very long stays, the nine non-respondents represent a very small number of Medicaid patients.

Only 29 percent of the joint hospitals responded. The joint hospitals include both children's hospitals within larger institutions and the pediatric departments of university teaching hospitals. All of the respondents were children's hospitals within an institution, while a sizeable portion of the non-respondents were pediatric departments.

The responding hospitals are larger on average than those in the universe of 90, as shown in Exhibit II-2.[10] The 37 responding freestanding acute children's hospitals average five beds more than the universe, but the nine responding joint hospitals are about one-third larger than the average for the 21 hospitals surveyed and the responding specialty care children's hospitals are 17 percent larger than those surveyed.

The 32 freestanding children's hospitals used in the financial analysis average 13 more beds than the respondents, while the four specialty children's hospitals in the financial analysis average one bed fewer.

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[9] Three hospitals may have include small or negligible amounts of uncovered Medicaid charges, as explained in the data analysis (Chapter VI).

[10] Data on the number of pediatric beds was unavailable for 11 joint and one specialty hospital.

Exhibit II - 1

Survey Response Status by Type of Children's Hospital and Region

Type of Children's Hospital	Region	Surveys Sent	Surveys Received	Percent Received
Freestanding	All	44	37	84%
	Midwest	13	11	85%
	North East	6	6	100%
	South	15	14	93%
	West	10	6	60%
Joint Hospitals	All	31	9	29%
	Midwest	8	4	50%
	North East	5	2	40%
	South	14	3	21%
	West	4	0	--
Specialty Hospitals	All	15	6	40%
	Midwest	4	0	--
	North East	6	4	67%
	South	4	2	50%
	West	1	0	--

Exhibit II - 2

Average Children's Hospital Bed Size by Survey Status and Hospital Type

Type of Children's Hospital	Hospitals Surveyed		Hospitals Responding		Hospitals Used in Financial Analysis	
	Avg Beds	Number of Hospitals	Avg Beds	Number of Hospitals	Avg Beds	Number of Hospitals
Acute Hospitals (Free + Acute)	174	66	156	44	200	32
Free Standing	182	44	187	37	200	32
Joint Hospitals	158	21	204	9	---	---
Specialty	70	14	81	6	80	4

Note: Number of Hospitals indicates only the number for which data were available.

Exhibit II - 3

Proportion of Care to Medicaid Patients by Type of Children's Hospital and Survey Status

Medicaid Gross Revenue
as a Percent of Total Gross Revenue

Type of Children's Hospital	Survey Status					
	Surveyed		Responded		In Finance Analysis	
	%	N	%	N	%	N
Acute						
All	28.8	56	28.4	42	29.2	32
Freestanding	28.6	41	28.5	35	29.2	32
Joint	29.1	15	27.9	7	--	--
Specialty	56.8	13	53.5	6	70.0	4

Note: Number of hospitals indicates only the number for which data were available.

Thus, the hospitals available for analysis are similar but somewhat larger in size than the non-respondents.

The responding hospitals are more similar to those surveyed in terms of the resources devoted to Medicaid patients, as shown in Exhibit II-3. For the freestanding acute care children's hospitals, there is less than a one percentage point difference between the universe, the respondents, and those in the financial analysis in terms of Medicaid gross revenue as a percent of total gross revenue. The responding joint and specialty care children's hospitals had slightly lower Medicaid percentages. The four specialty children's hospitals in the financial analysis have Medicaid loads 23 percent larger than the universe.

3. Case Mix Data

The analysis of Medicaid case mix and differences in case mix between Medicaid and non-Medicaid inpatients in Chapter IV is based on a large hospital discharge abstract data base maintained for NACHRI by Health Knowledge Systems, Inc. (HKS, which was formerly the Commission on Professional and Hospital Activities, known as CPHA). The data base contains records for a confidential sample of the teaching and non-teaching general hospitals which voluntarily subscribe to the Professional Activities Study (PAS), plus the NACHRI members who participate in NACHRI's Case Mix Data System.

The data base used for the study includes pediatric and non-normal newborn discharges in calendar 1986 for 225,030 discharges from 35 children's hospitals, 113,365 discharges from 45 teaching hospitals, and 91,884 discharges from 150 community hospitals. Because of regional variation in the level of voluntary participation, hospitals in the West may be somewhat under-represented. Although the data are processed through a series of edits, the analysis relies on the hospital's own designation of expected principal payor.[11] Since Medicaid eligibility can be retroactively granted or denied, there is likely to be some degree of inaccuracy in so far as individual patients are concerned. However, the net aggregate effect should be minimal, since the retroactive additions and denials can be expected to offset each other.

The data were analyzed using the NACHRI Pediatric-Modified DRG (PM-DRG) classification system, which provides a higher degree of specificity and consistency of resource use within each category for children than DRGs. The grouper software program for assigning PM-DRGs is a proprietary product of Health Systems International., Inc. of New Haven, Connecticut, the same organization which produces the official HCFA DRG grouper.

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[11] Three children's hospitals were excluded from the analysis after the initial runs disclosed their payor source data to be questionable. It was not possible to examine hospital specific data for the other hospital groups because of the confidential nature of the data base.

Chapter III

The Medicaid Program

Introduction

This chapter provides a basic description of the Medicaid program, including its objectives, the operational roles of the federal and state governments, the criteria used to determine who is eligible, the types of services which must or may be covered, and the reimbursement methods which may be used to pay health care providers.

Although this overview of the Medicaid program is a summary, the inordinate complexity of Medicaid is unavoidable even in a summary. This summary will help the reader to better understand the context and technical detail behind the Medicaid problems addressed in later chapters. However, reading Chapter III is not essential to understanding most of what is in the remainder of the report.

Medicaid is a very complex program with wide variations from one state to another. This is because there are many options which states can elect, but only a few requirements on who is entitled to Medicaid and the services which must be covered. Because of this complexity, this chapter will provide only a general overview of options and only examples of the choices which states have made in designing their Medicaid programs.[1]

One result of the wide range of Medicaid program design options and the variety of ways states have elected to implement the program is that there are major gaps and inequities in the way Medicaid serves children. Poor children who are eligible in one state are ineligible in another. Essential services provided in one state are not covered for children in another. Furthermore, in order to enroll in Medicaid, children must often meet more stringent eligibility criteria than adults.

Although this chapter is largely descriptive, the reader should be aware that the variations, gaps, and inequities documented here have significant negative impacts on the ability of poor children to access health care services. The sections which follow will present the effects of these state options and choices, including the result that, in 1986 almost half of all poor children were not served by Medicaid.

A. Medicaid Program Objectives

The fundamental objective of the Medicaid program is to enable poor and medically indigent individuals and families to access health care services. The Social Security Amendments of 1965, which created the Medicare program, also established Title XIX of the Social Security Act, the means-tested entitlement program of medical assistance vendor payments which is known now as Medicaid.

The law established a direct link between eligibility for medical assistance and eligibility for the cash welfare assistance programs supported by the federal government. It also gave states the option to entitle certain other individuals and families. However, contrary to popular belief the law did not, and still does not, entitle all of the poor to Medicaid.

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[1] For details on Medicaid eligibility and service coverage options, see "Medicaid and Poor Children," "Medicaid Source Book, and "Analysis of State Medicaid Program Characteristics, 1986" (Health Care Financing Administration, Baltimore, Maryland, August 1987).

Medicaid was established as a health care access program, not a health insurance program. Traditional forms of health insurance, and to a certain extent Medicare, provide financial protection to individuals against the risk of large health care costs by compensating (indemnifying) consumers for some or all of their out-of-pocket costs. In contrast, Medicaid pays the provider of care directly and requires providers to accept Medicaid payments as payment in full (except for medically needy spend-down amounts and nominal cost-sharing when permitted). Also, Medicaid is, by law, the payor of last resort.[2]

That Medicaid's primary objective is access to care is also evident in the law's requirements that Medicaid enrollees have freedom of choice in provider and in the long-standing regulatory requirement that payment rates be sufficient to provide the same level of access to care as the general public. Also, many of the discussions and literature relating to the initial implementation of the program refer to expectations that Medicaid would "mainstream" the poor; that is, break their dependency on public clinics and charity care providers and facilitate their access to private practitioners and voluntary and private hospitals.

The importance of promoting health was also established as an objective in several of the earliest amendments. The 1967 amendment establishing the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program required that states both cover preventive services for children and take an active role in promoting use of these services. Also, the far-reaching amendment prohibiting diagnostic and condition-specific limits on covered benefits was added specifically to ensure that pregnant beneficiaries had access to prenatal and obstetrical care.

The original law and early history suggest that adequate payment to providers was not an objective. The original law required payments to institutions to be reasonably related to costs, whereas the Medicare title of the same act required cost-based payments to institutions and used prevailing charges as a basis for reimbursing physicians' services. Medicaid was and continues to be viewed by policymakers and providers as a marginal payor (but for different reasons). A common view was that providers should be happy to receive inadequate payment from Medicaid (as payment in full), since without Medicaid there would be little or no revenue from the care provided to the poor. To this day, the policy discussions on Medicaid payment issues revolve not around whether rates adequately compensate providers' costs, but whether access is jeopardized.

B. Federal and State Roles in the Funding and Operation of the Medicaid Program

The Medicaid program is best described as a joint federal-state program. The federal government sets the basic rules and regulations, conducts general oversight of state operations, and provides federal "matching" funds. The states elect to operate a Medicaid program, decide which optional eligibility groups to serve and which optional services to offer, and administer the program, often through the county or municipal welfare agencies.[3]

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[2] In contrast, insurance companies will typically coordinate benefits in situations of overlapping coverage.

[3] Although Medicaid is optional, almost all states elected to offer the program within a short time after passage of Title XIX. In 1982, Arizona became the last state to offer a medical assistance program. Because the Arizona Medicaid program, known as ACCESS, is officially a Section 1115 demonstration and has been exempted from many of the standard Medicaid requirements, we have generally excluded it in as a Medicaid state for purposes of this report. Also, for simplification of presentation, the District of Columbia is included in all references to states in this report.

The federal government reimburses states between 50 percent and a maximum of 83 percent of states' actual outlays for health services, with the matching rate percentage (referred to as the FMAP rate) varying according to state per capita income.[4] Administrative costs are matched at rates from 50 to 100 percent depending on the nature of the expenditure. In 14 states, county governments fund up to 50 percent of the state's cost share.[5] Under regulations in effect as of April, 1989, private funds donated to the Medicaid agency can be counted as state expenditures for purposes of computing the federal match.[6]

Each state must designate a single state agency to be responsible for eligibility determinations, provider qualification, claims processing, and program integrity. However, the actual operations can and often are delegated. Eligibility processing is often done by county welfare or social service agencies; the state health department often performs provider qualification reviews; and fiscal agents are frequently used to pay claims. The state must operate under a HCFA-approved "state plan." States periodically submit state plan amendments to reflect changes in eligibility, benefits, payment methods, and operations. HCFA reviews state plans and amendments for compliance with federal regulations and law. HCFA also conducts several types of oversight reviews to ensure the program is operated in accord with the state plan and to determine eligibility and payment determination errors that can result in loss of federal matching funds and in penalties.

Under certain circumstances, HCFA can waive specific requirements of Medicaid law and regulation, for example to restrict freedom of choice in capitated care programs, to offer alternatives to long-term institutional care or to conduct research and demonstration projects.

C. Eligibility Groups

Medicaid provides eligibility to only certain categories of individuals and families. There are three broad groups which states must or can cover under Medicaid and several categories of individuals and families covered within these groups. The three groups are:

- Mandatory categorical eligibles -- generally people receiving or eligible to receive cash assistance welfare under the state-run Aid to Families with Dependent Children (AFDC) program or the federal Supplemental Security Income (SSI) program for the aged and disabled;
- Optional categorically needy -- people whom states elect to cover who meet the financial criteria for cash assistance but do not meet certain other criteria (e.g. non-dependent children), as well as low income pregnant women and poor children whose family income exceeds the cash welfare level;
- Optional medically needy -- people whom states elect to cover who meet categorical criteria for the groups above, but have incomes above the welfare assistance level.

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[4] The maximum percentage in effect in federal Fiscal Year 1989 is Mississippi's 79.8 percent match. Source: "Medicaid Source Book," p. 197.

[5] "Medicaid Source Book," p. 200.

[6] Certain restrictions on use of donated funds apply. Source: 42 CFR 433.45.

1. Mandatory Categorical Eligibility:

The persons who must be covered include:

- AFDC cash assistance recipients: families with an absent or incapacitated parent (whose children are thus "dependent") in which income and assets do not exceed a state-set level;
- Families eligible for AFDC who decline to accept cash payments;
- Children under the age of seven in two-parent families that meet financial criteria for AFDC, but are ineligible for AFDC because AFDC covers only "dependent" children;
- Pregnant women and infants (up to the age of one) whose income is below 100 percent of the federal poverty level (during a phase in from July 1, 1989 to June 30, 1990 the income level is set at 75 percent of poverty), regardless of family structure;
- Elderly and permanently disabled persons who, at state option, either receive federal SSI payments or optional state SSI supplements only (36 states), or meet more restrictive state-set financial and disability criteria (in the 14 states which have elected the "209(b)" option to use criteria no more restrictive than those they used in 1972 prior to federalization of SSI).

Although the SSI disabled group is perceived to include only adults, approximately 14 percent of recipients are children.[7]

2. Optional Categorically Needy:

States can elect to cover certain children and adults who do not meet cash welfare requirements. These include:

- All children in families with incomes and assets low enough to qualify for AFDC, but who are ineligible for AFDC because they are not "dependent."[8]
- Adults and children in two-parent families which meet AFDC financial requirements where the principal wage earner is unemployed.[9]
- Children up to the age of eight in families with incomes below 100 percent of the federal poverty level, regardless of family structure;

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[7] "Medicaid and Poor Children," p. 20.

[8] This group is often called the "Ribicoff children." All states cover the optional Ribicoff children (i.e., those who are age seven and older), but 19 restrict eligibility to children living outside the home in alternate living arrangements. The mandatory eligibility group of children under age seven in two-parent families with incomes below the AFDC threshold is sometimes referred to as mandatory Ribicoff children.

[9] Currently states can elect to provide both AFDC assistance and Medicaid to this group or just Medicaid alone. Under the provisions of the 1989 Family Assistance Act, beginning October 1, 1990 all states must provide year-round Medicaid coverage and at least six months per year of AFDC support to families with an unemployed parent who meet income standards.

- Pregnant women and infants up to the age of one in families with incomes below 185 percent of the federal poverty level, regardless of family structure; and
- Certain disabled children living in the community who would otherwise only be eligible for Medicaid because of special income rules that apply to institutionalized persons.[10]

3. Optional Medically Needy:

This group is comprised of individuals who fit in the categories above (other than those for pregnant women and young children that are based on a percent of the federal poverty level) but do not meet the financial criteria for these categories. Instead, they qualify on the basis of special medically needy income and resource (asset) criteria that are described in the next section.

D. Financial and Other Eligibility Criteria

There are two basic types of financial criteria which determine eligibility for Medicaid: income and assets (or "resources"). The actual criteria differ by category of eligibility and vary from one state to the next. The criteria which are linked to welfare eligibility are described below. Subsequent sections address eligibility under the medically needy option and the options to expand eligibility for pregnant women and young children.

1. AFDC and SSI Income Standards:

The AFDC program is state-run, like Medicaid, and states are free to set the income eligibility levels. Exhibit III-1 displays the annualized AFDC income eligibility thresholds and shows the very wide variation across the states, ranging from 14 percent of poverty in Alabama up to 79 percent of poverty in California as of January 1989. In the average state, income above 47 percent of the federal poverty line disqualifies the family for cash assistance and, thus, in many cases Medicaid as well.

In contrast, the SSI program for the aged and disabled is federally-run and sets a uniform floor on income eligibility for Medicaid in most states at 76.1 percent of the federal poverty line(as of January 1987), as shown in Exhibit III-2. Four "209(b)" states use a lower level, while 24 states supplement SSI, which boosts the eligibility level. As of January 1987, the average SSI income eligibility level was 81.7 percent of poverty, or more than half again as high as for children and parents under AFDC in January 1989. Also, the SSI income eligibility level is indexed to inflation, but AFDC criteria are not.

There is a special feature of the SSI income eligibility determination not found in AFDC that has an important effect on children's access to Medicaid.[11] After a disabled child meeting the SSI definition of permanent disability is in a hospital or other institution for one month, the disabled child's SSI

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[10] These include Section 2176 Home and Community-based Care Waivers, Katie Beckett waivers, and the TEFRA Section 134 and OBRA 1986 Respiratory Home Care state plan options.

[11] States that elect to use more restrictive criteria from 1972 do not necessarily follow this rule. However, because they are required to subtract health care costs from income in determining eligibility, their SSI eligibility functions like a medically needy program.

Exhibit III - 1

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS

AFDC, MEDICALLY NEEDY,
OBRA 86/87 PREGNANT WOMEN – JANUARY 1989

	AFDC FAMILY OF 3	PERCENT OF POVERTY $10,060	MEDICALLY NEEDY FAMILY OF 3	PERCENT OF POVERTY $10,060	OBRA-86/87 PREGNANT WOMEN FAMILY OF 3	PERCENT OF POVERTY $10,060
Alabama	$1,416	14.1%	$——		$10,060	100.0%
Alaska	9,708	77.2%			12,580	100.0%
Arizona	3,516	35.0%			10,060	100.0%
Arkansas	2,448	24.3%	3,300	32.8%	10,060	100.0%
California	7,956	79.1%	10,704	106.4%	18,611	185.0%
Colorado	5,052	50.2%				
Connecticut	6,408	63.7%	8,520	84.7%	18,611	185.0%
Delaware	3,996	39.7%			10,060	100.0%
D.C.	4,716	46.9%	5,820	57.9%	10,060	100.0%
Florida	3,444	34.2%	4,596	45.7%	10,060	100.0%
Georgia	4,512	44.9%	4,404	43.8%	10,060	100.0%
Hawaii	6,684	57.8%	6,684	57.8%	11,570	100.0%
Idaho	3,648	36.3%			6,740	67.0%
Illinois	4,104	40.8%	5,496	54.6%	10,060	100.0%
Indiana	3,456	34.4%			5,030	50.0%
Iowa	4,728	47.0%	6,300	62.6%	15,090	150.0%
Kansas	4,812	47.8%	5,760	57.3%	10,060	100.0%
Kentucky	2,616	26.0%	3,504	34.8%	12,575	125.0%
Louisiana	2,280	22.7%	3,096	30.8%	10,060	100.0%
Maine	7,584	75.4%	7,092	70.5%	18,611	185.0%
Maryland	4,524	45.0%	5,304	52.7%	10,060	100.0%
Massachusetts	6,948	69.1%	9,300	92.4%	18,611	185.0%
Michigan	6,864	68.2%	6,588	65.5%	18,611	185.0%
Minnesota	6,384	63.5%	8,508	84.6%	18,611	185.0%
Mississippi	4,416	43.9%			18,611	185.0%
Missouri	3,420	34.0%			10,060	100.0%
Montana	4,308	42.8%	4,896	48.7%		
Nebraska	4,368	43.4%	5,904	58.7%	10,060	100.0%
Nevada	3,960	39.4%				
New Hampshire	5,952	59.2%	6,852	68.1%		
New Jersey	5,088	50.6%	6,792	67.5%	10,060	100.0%
New Mexico	3,168	31.5%			10,060	100.0%
New York	6,468	64.3%	8,508	84.6%		
North Carolina	3,192	31.7%	4,296	42.7%	10,060	100.0%
North Dakota	4,632	46.0%	5,220	51.9%		
Ohio	3,852	38.3%			10,060	100.0%
Oklahoma	5,652	56.2%	5,196	51.7%	10,060	100.0%
Oregon	4,944	49.1%	6,708	66.7%	10,060	100.0%
Pennsylvania	4,608	45.8%	5,400	53.7%	10,060	100.0%
Rhode Island	6,204	61.7%	8,304	82.5%	18,611	185.0%
South Carolina	4,836	48.1%			10,060	100.0%
South Dakota	4,392	43.7%			10,060	100.0%
Tennessee	4,380	43.5%	2,796	27.8%	10,060	100.0%
Texas	2,208	21.9%	3,204	31.8%	10,060	100.0%
Utah	6,024	59.9%	6,012	59.8%	10,060	100.0%
Vermont	7,548	75.0%	10,092	100.3%	18,611	185.0%
Virginia	3,492	34.7%	4,296	42.7%	10,060	100.0%
Washington	5,904	58.7%	7,188	71.5%	9,054	90.0%
West Virginia	2,988	29.7%	3,480	34.6%	15,090	150.0%
Wisconsin	6,204	61.7%	8,268	82.2%		
Wyoming	4,320	42.9%			10,060	100.0%
AVG. STATE	$4,791	47.1%	$6,048	60.1%	$11,974	118.1%

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JANUARY 1989

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EXHIBIT: III - 2

Annualized SSI Medicaid Eligibilty Thresholds--As Percent of Poverty (As of January 1987)

States	SSI Independent Individual	Percent of Poverty (5,360)	States	SSI Independent Individual	Percent of Poverty (5,360)
Alabama	$4,800	89.6%	Montana	$4,080	76.1%
Alaska	7,584	113.2	Nebraska	4,692	87.5
Arizona	4,080	76.1	Nevada	4,517	84.3
Arkansas	4,080	76.1	New Hampshire	4,248	79.3
California	6,720	125.4	New Jersey	4,455	83.1
Colorado	4,776	89.1	New Mexico	4,080	76.1
Connecticut	5,828	108.7	New York	4,943	92.2
Delaware	4,080	76.1	North Carolina	2,796	52.2
District of Columbia	4,260	79.5	North Dakota	4,080	76.1
Florida	4,080	76.1	Ohio	3,456	64.5
Georgia	4,080	76.1	Oklahoma	4,848	90.4
Hawaii	3,600	67.2	Oregon	4,100	76.5
Idaho	4,716	88.0	Pennsylvania	4,469	83.4
Illinois	n/a	n/a	Rhode Island	4,754	88.7
Indiana	4,080	76.1	South Carolina	4,080	76.1
Iowa	4,080	76.1	South Dakota	4,260	79.5
Kansas	4,080	76.1	Tennessee	4,080	76.1
Kentucky	4,080	76.1	Texas	4,080	76.1
Louisianna	4,080	76.1	Utah	3,468	64.7
Maine	4,200	78.4	Vermont	4,769	89.0
Maryland	4,080	76.1	Virginia	4,080	76.1
Massachusetts	5,626	105.0	Washington	4,416	82.4
Michigan	4,430	82.6	West Virginia	4,080	76.1
Minnesota	4,500	84.0	Wisconsin	5,300	98.9
Mississippi	4,080	76.1	Wyoming	4,320	80.6
Missouri	4,080	76.1			
			Average State	4,411	81.7

Source: State Medicaid Information Center, National Governors' Association, January 1987.

eligibility is determined solely on the basis of child's income, rather than the whole family's income.[12] Through this SSI parental income "deeming" rule, some children from families with incomes above the welfare level who lack or exhaust their health insurance can become Medicaid eligible. However, the children will lose this eligibility upon leaving the institution unless the state has a Section 2176 Home and Community-based Care waiver program which serves children or has elected the state plan option to extend eligibility to disabled or respirator-dependent children. In the 17 states which have not elected one of these options, those disabled children whose families can not afford care at home have no alternative but to remain in an institution.

2. AFDC and SSI Asset Standards:

Qualification for Medicaid on the basis of AFDC or SSI eligibility is also based on the assets or "resources" of the individual or family unit.[13] SSI recipients are allowed considerably more assets than an AFDC family.

The asset (resource) limits for AFDC were set uniformly for all states by the Congress in 1981 at:

- Personal effects and liquid resources not to exceed $1000;
- One automobile not to exceed $1,500 in value;
- One burial plot;
- A home of any value.

The SSI resource standards are much less restrictive. SSI and AFDC resource standards and other features are contrasted in Exhibit III-3.

E. Medically Needy Program Option

The medically needy program option, adopted by 36 states, adds to Medicaid those persons and families whose income and/or assets exceed the AFDC or SSI limits.[14] However, as currently operated, the medically needy program falls short of preventing medical indigence.

By federal law the state-set medically needy income level may not exceed 133 percent of the AFDC limit. As a result only two states have medically needy income limits which reach the federal poverty line. The average state's medically needy income limit was only 60.1 percent of the federal poverty level as of January 1989 (see Exhibit III-1).

Higher income individuals and families can also qualify as medically needy if their medical expenses "spend-down" their income to the eligibility level. Eligibility can be established retroactively up to three months. Thus, after major medical expenses are incurred Medicaid coverage can be obtained to pay a portion of the bills.

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[12] A "permanent" disability is one which has lasted or can be expected to last at least 12 months. The disability must be of "comparable severity' to one which would make an adult unemployable.

[13] The word "resources" is the official term in the Medicaid law and regulations.

[14] Two states limit their medically needy programs to pregnant women and children.

EXHIBIT: III - 3

Comparison of AFDC and SSI Income and Resource Eligibility Standards

Income Standards:	AFDC	SSI
1) Minimum Level:	None	Federal Standard -- most states State Standard -- 4 states (i.e., "209(b)" states)
2) Inflation Indexing:	No	Yes (Federal Standard)
3) Standards as a Percent of Poverty:[1]		
a) Actual Minimum	14.6% (AL)	52.2% (NC)
b) Average State	48.0%	81.7%
c) Actual Maximum	78.4% (CA)	125.4% (CA)
4) Higher Level Allowed in Institutionalized Persons	No	Yes - 300% of Federal Standard (=228.3% of Poverty Line)
Resource Standards		
1) A home of any value	Yes	Yes
2) Automobile	Market Value <=$1,500	Market Value <=$4,500
3) Personal effects	Market Value <=$1,000	Market Value <=$2,000
4) Liquid resources	Included in personal effects limit of $1,000	$1,900/individual $2,850/couple
5) One burial plot	Yes	Yes
6) Burial expense	No provision	<=$1,500
7) Life insurance	No provision	Face value <=$1,500

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[1] AFDC standards as of April 1988 and SSI standards as of January 1987. Source: National Governors' Association.

The maximum allowable resources (assets) allowed the medically needy vary by state. As of July 1987, the resources allowed a two person family ranged from $2250 to $6450.

While the medically needy spend-down provision functions as a sort of catastrophic "wrap-around" policy for children with inadequate or no health insurance, it may not be very effective in helping low income uninsured children to access primary or chronic care and it may create large uncompensated care burdens for providers. The reason is that the spend-down requires that sufficient expenses be incurred; it is not necessary to actually pay the spend-down amount to obtain Medicaid eligibility. Thus, families may have access problems in finding providers willing to provide care when Medicaid eligibility is in question until the bill is large enough and then Medicaid will pay only part of the bill.

Furthermore, there is no cap on the amount of the spend-down and the income levels are so low that families must impoverish themselves before coverage begins. A three person family with an income of $30,000 would have had to spend 80 percent of its income on health care to qualify in the average state in 1988. The prospects of incurring such large personal debt may act as a barrier to needed and timely care.

F. Medicaid Covered Services

Federal regulations require states to offer a basic package of services to all categorically eligible individuals, but they need not offer the same services to the medically needy group. Most states cover the same services for both groups, but some states exclude even mandatory services from their medically needy programs.[15] States are free to offer any medical or health services but do not have to cover all medical services. States may put limits on the amount, duration, and scope of services, including mandated services.

1. Mandatory Benefits:

The mandatory benefits include: inpatient hospital services, outpatient hospital services, physician services, rural health clinic services, other laboratory and X-ray services, skilled nursing care for individuals over 20 years of age, home health services, family planning services and supplies, nurse-midwife services, and early and periodic screening, diagnosis, and treatment (EPSDT).[16]

EPSDT is a special preventive and treatment package specifically for children. It includes features that differ considerably from other service requirements. Under EPSDT requirements, states must include vision and hearing treatment, dental care, and immunizations, even if these services are not included in the state plan. States also have the discretion to include expanded or other services for children under EPSDT that are more limited or not covered for other Medicaid enrollees. Examples include dental services, eyeglasses, and longer hospital stays.

EPSDT is akin to a service delivery program, rather than just health care financing. States must have active outreach programs and must assist children in obtaining appropriate treatment of conditions detected in screening and diagnosis.[17]

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[15] For example, New Jersey's medically needy program excludes EPSDT services and only provides inpatient hospitalization to pregnant women for delivery.

[16] "Medicaid and Poor Children," p. 44.

[17] At a minimum the outreach component must include informing eligibles annually.

2. Limits on Mandatory Services:

Many states limit the amount of mandatory covered services which recipients can obtain.[18] As of March 1986, all but four states had limits on inpatient care, including limits on the number of covered days, prior approval requirements, and exclusions of certain procedures.[19] Ten states had limits on children's inpatient stays as of January 1989, ranging from 12 days per stay in Alabama to 45 days per year in Florida.[20] Most states also place limits on outpatient services, with 11 limiting the number of visits without regard to medical necessity. Almost half the states limit laboratory and radiology services.

EPSDT services are also constrained. Only seven states provided the full screening periodicity schedule recommended by the American Academy of Pediatrics as of 1985.[21] Twenty-six states provided only the minimum benefits required by HCFA while the remainder provided a richer package of services.[22]

3. Optional Services:

States have elected to offer a wide variety of other services under their state plans, often with limits applying. For example, all but one state covers prescription drugs, while 46 cover eye glasses, 45 cover dental care, 49 provide transportation, 46 cover certain free-standing clinics, 37 provide some degree of inpatient and/or outpatient rehabilitative services, and 35 cover inpatient psychiatric hospital stays.

Although states must provide comparable service coverage to all categorical eligibles (excepting EPSDT recipients), they may obtain Section 2176 Home and Community-based Care waivers to provide otherwise uncovered or limited services to specific individuals who would otherwise require long-term institutional care. These waivers have sometimes been used to provide home care for technology dependent children, but only a few states have programs designed specifically for this group.

G. Reimbursement Rates and Methods

States have wide discretion in selecting the methods and rates of payment for Medicaid services. Federal law in general simply requires that payments be "consistent with efficiency, economy, and quality of care."[23] By regulation, payment rates must be attract sufficient provider participation that services are as available for Medicaid beneficiaries as they are for the general public.[24]

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[18] States may exclude and/or refuse to pay for any service which is not "medically necessary," including experimental treatments.

[19] "Medicaid and Poor Children," p. 45.

[20] The states with limits were Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Oregon, Tennessee, Texas, and West Virginia. Source: NACHRI Survey of State Medicaid Reimbursement Policies for Inpatient Care, unpublished, January 1989.

[21] "Medicaid and Poor Children," p. 44.

[22] "Medicaid and Poor Children," p. 45.

[23] U.S.C. 1396a(a)(30).

[24] 42 CFR 447.204.

1. Hospital Inpatient Payments:

Medicaid law originally required that payments to hospitals be reasonably cost-related. OBRA 1981 gave states wide flexibility to develop payment methods by deleting this requirement. Instead, states are free to set the rates paid individual hospitals, provided that the rates cover the costs of efficiently and economically operated hospitals meeting quality of care standards.[25] (This requirement is often referred to as the "Boren amendment.") The 1981 law also required states in setting rates to consider the situation of hospitals with a disproportionate number of low income patients with special needs.

By January 1989, 42 states had converted to some form of prospective rates for hospitals, with only eight using retrospective cost-based methods.[26] Of the 42 Medicaid programs with prospectively set payment rates, 17 modeled their payment systems in whole or in part on Medicare's PPs, using either Medicare DRGs or a state-developed illness classification system on which to base the amount of payment per discharge.[27] Three states (California, Illinois, and Vermont) used competitive contracting to set prospective rates (and aggregate facility-specific patient volume ceilings, in the case of Illinois).

Due to the states' failure to implement payment adjustments for hospitals with a disproportionate share of low income patients, the Congress enacted as part of OBRA 1987 minimum standards defining disproportionate share hospitals and required that Medicaid programs make payment adjustments in proportion to the degree to which these hospitals' Medicaid volumes exceeded the minimum threshold. As part of the 1988 Medicare Catastrophic Care Act, the Congress added a requirement that all prospective payment systems must make adequate payments for the care of infants up to age one who had exceptionally long or costly stays in disproportionate share hospitals.

It is important to note that HCFA neither sets criteria nor collects data by which to review whether state payment rates meet the costs of efficiently run hospitals. However, HCFA does apply a crude inflation-adjusted limit (often called a TEFRA limit, in reference to a similar type of limit used by Medicare for certain hospitals) to ensure states are not paying hospitals too much. In 1986, the Congress prohibited HCFA from limiting disproportionate share payments.

2. Hospital Outpatient Payments:

Although there is no explicit maximum on hospital outpatient payments in law, HCFA regulations limit Medicaid outpatient payments to the amount allowable under Medicare in comparable circumstances.[28] The Boren amendment refers to hospital services in general and, thus, applies to hospital outpatient and other hospital services.[29]

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[25] U.S.C. 1396a(a)(13).

[26] "Medicaid Source Book," p. 125.

[27] Susan S. Laudicina, "State Systems for Hospital Payment," Intergovernmental Health Policy Project, The George Washington University, Washington, D.C., April 1989, pp. 3-4.

[28] 42 CFR 447.321.

[29] Ohio Hospital Association et al. v. The Department of Human Services, Court of Claims of Ohio, Case No. 88-04961 (Filed November 2, 1988).

In federal fiscal year 1987, 23 states used retrospective cost-based reimbursement, nine used prospective methods, eight used fee schedules comparable to those used for physician services, and the remainder used a variety of prevailing charge or cost screen methods.[30]

3. Physician Payments:

Thirty-one states pay physicians according to fee schedules or relative value scales. Prevailing charge screens are used in 19 states. The rates paid to physicians have often been criticized as inadequate and low payments have been cited as a major factor in the difficulties pregnant Medicaid beneficiaries have experienced in accessing prenatal care. Payments for a brief General Practitioner office visit ranged from a low of $6 to a high of $20 in 1986, while rates for obstetrical care ranged from $214 in New Hampshire to $1027 in the adjoining state of Massachusetts.[31] In at least 10 states the Medicaid brief office visit payment was less than half of the amount allowed by Medicare.[32]

4. Promptness of Payments:

For physicians and other practitioners in individual or group practices and in shared health facilities, states are required to pay 90 percent of "clean" claims within 30 days and 99 percent within 60 days.[33] All other providers must be paid within 12 months of receipt of a payable claim.[34]

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[30] "Medicaid Source Book," p. 138.

[31] "Medicaid and Poor Children," p. 12.

[32] Data was unavailable for seven states. Source: "Medicaid Source Book," pp. 450-451.

[33] U.S.C.11396a(a)(37).

[34] 42 CFR 447.45.

Chapter IV

Medicaid and Poor Children: Gaps in the Social Safety Net

Introduction

In an era when one of every five infants is born into poverty and when only fifteen percent of children living below the poverty line have private health insurance coverage, there is much reason to question whether Medicaid is functioning as an effective social safety net for children.[1]

The available data on Medicaid eligibility and service coverage and on the commitment of Medicaid resources to the health care of children further amplifies concern about the program's inadequacies. Coupled with what is known about the poor health of children today, our lack of progress toward improved child health, and the effects of poor health on educational attainment, the current state of the Medicaid program for children bodes ill for the future health of the American economy.

NACHRI's recent assessment of the state of child health reveals many problems and little progress towards the U.S. Surgeon General's 1990 child health goals.[2] A key barrier to improving the poor state of child health is inadequate financial access to health care services, particularly among the poor.

At the same time, we hear of the plight of employers who can not find healthy, educated, motivated young people to fill new jobs. Our health professionals and educators know first hand and research studies amply document that poor child health is a barrier to education.

As a matter of social conscience and as a matter of direct self-interest, this Nation has a stake in investing in the health and education of its young. Medicaid is one of the primary societal mechanisms through which we make this investment. Our past investment policy has fallen far short of the mark, but recent and proposed reforms in the design of the Medicaid program promise a brighter future.

This section looks at our Nation's investment in child health through the Medicaid program. It examines the importance of Medicaid in financing children's health care, the problems in the design and implementation of Medicaid which cause it to fall short of its goals, and the recent efforts to improve the effectiveness of the Medicaid program in ensuring poor children's access to care. The highlights of this section are:

- Medicaid covered only half of all poor children in 1986 because Medicaid eligibility is tied to state-set AFDC welfare eligibility levels that are too low in general, vary too widely, and which in some states exclude children in two-parent families, no matter how needy.
- Children covered by Medicaid may have difficulties accessing the services they need because of Medicaid service restrictions, reimbursement rates which are too low to attract an adequate supply of care providers, and shortcomings in coverage for the medically needy.

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[1] The federal poverty level standard for 1988 is $10,060 for a family of three in the mainland U.S. In Alaska the poverty level is $12,580 and in Hawaii it is $11,570.

[2] Patricia A. Sealing, "Profile of Child Health in the United, States," NACHRI, Alexandria, Virginia, 1989, p. 9.

- Children are more dependent on Medicaid than the elderly and disabled, much less expensive to serve, yet suffered disproportionate cuts in their Medicaid health care purchasing power during the Medicaid cost containment of 1981-84.
- The Congress and the states have introduced precedent-setting reforms since 1984 to expand Medicaid eligibility to a larger share of poor children, to make the program more uniform, and to provide more adequate service coverage and payment levels.
- Medicaid reforms need to be expanded to provide children with a health care safety net comparable to that offered the aged and disabled and to ensure adequate access to care for those covered by Medicaid.

A. Financing Health Care for Poor Children

Medicaid is the largest single public program financing health care services for children. Medicaid spending on health care for children under 21 totaled $8.0 billion in Fiscal 1986.[3] In contrast, federal funding for the next largest child health program, the Maternal and Child Health Services Block Grants was $457 million in 1986.[4]

Children are the largest and most vulnerable group relying on Medicaid, and Medicaid alone, for access to health care. Children comprise half of all Medicaid recipients, the largest single group within Medicaid (see Exhibit IV-I).[5] Among those poor children who have any health coverage, 80 percent rely on Medicaid for access to care. In contrast to our other vulnerable populations, the elderly and disabled, there is no broad-based health program like Medicare for children. Yet the Medicaid program devotes 80 percent of its resources to groups which also benefit from Medicare -- the elderly and disabled -- as shown also in Exhibit IV-1.[6]

Even though children comprise the majority of Medicaid recipients, Medicaid leaves a large gap in health care financing for poor children and for uninsured and under-insured children. As a recent evaluation of Medicaid noted, "especially for working-age adults and their children, current eligibility for Medicaid is contingent upon virtual destitution."[7] According to the most recently available data, slightly over half (51.8%) of all poor children (children in families with income below 100 percent of the federal poverty

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[3] "Medicaid Source Book," p. 311.

[4] Vince L. Hutchins, Eamon M. Magee, and Margaret W. Pratt, "Understanding Title V of the Social Security Act: A Guide to the Provisions of Federal Maternal and Child Health Services Legislation," Information Sciences Research Institute, Vienna, Virginia [undated], p. 2.

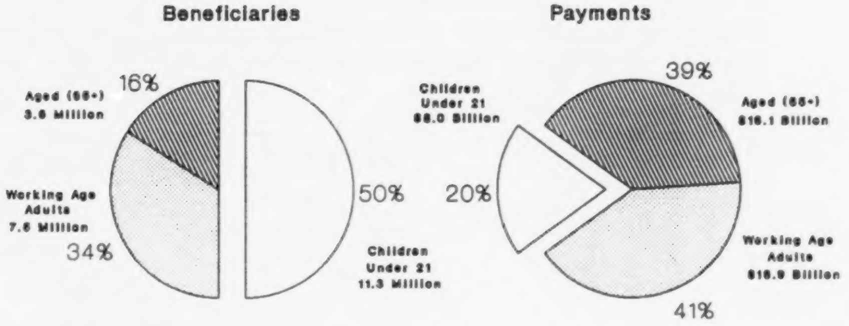
[5] "Medicaid Source Book," p. 312.

[6] Note that although almost all elderly are covered by Medicare, the same is not true of the disabled because of the two year waiting period and inadequate work credits for some disabled, particularly disabled children. Source: "Medicaid Source Book", p. 312.

[7] Lucy Johns and Gerald Adler, "Evaluations of Recent Changes in Medicaid," Health Affairs, Spring 1989, p. 174.

Exhibit IV - 1

Medicaid Beneficiaries and Payments,
By Age of Beneficiaries, FY 1986



Source: "Medicaid Source Book," p. 312 - Congressional Research Service Analysis of HCFA 2082 Data.

line) were covered by Medicaid in 1986.[8] However, as shown in Exhibit IV-2, almost one-third (32.8%) of all poor children had no insurance at all.

The problem of uninsurance is at lease as severe for those near-poor children in the group between 100 percent and 150 percent of poverty. They are more likely to have no insurance than those living below poverty (33.4% vs. 32.8%). Further, almost one in every four children (24.2%) between 150 percent and 200 percent of poverty also lacks health insurance.[9] For these groups, private insurance, rather than Medicaid, is the primary source of insurance (as shown in Exhibit IV-2). However, these are also the groups in which the loss of private insurance from 1979 to 1986 has been the largest.[10]

Although these data point to a major gap in the Medicaid safety net for poor and near poor children, the same data also suggest that Medicaid should be viewed as an essential component of any effort to resolve the overall problem of uninsured children. This is because over half (53.8%) of the total 12

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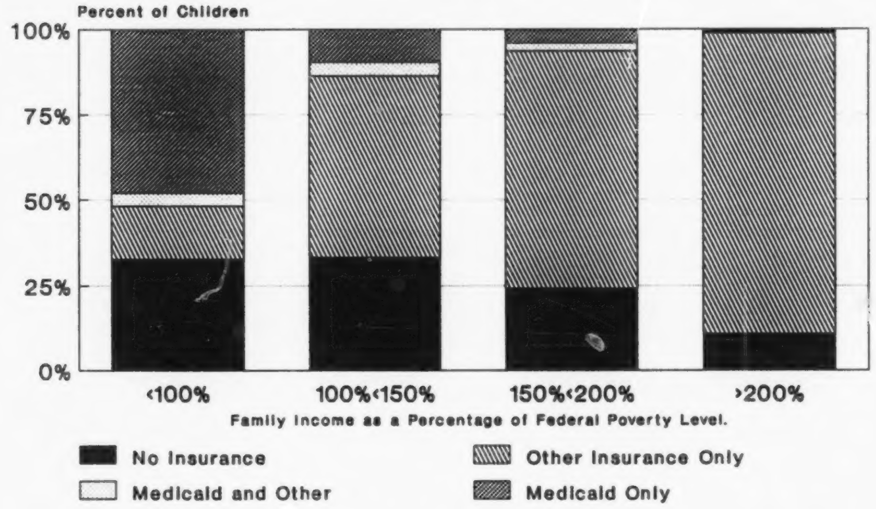
[8] The Current Population Survey, upon which these data are based, asks about multiple insurance coverage but does not explicitly determine whether a person's dual coverage includes Medicaid. It is usually assumed that dual coverage includes Medicaid, thus probably overstating Medicaid enrollment. Source: "Medicaid Source Book," p. 333.

[9] Ibid.

[10] Children's Defense Fund, unpublished analysis of CPS data for 1979 and 1986.

Exhibit IV - 2

Health Insurance Status of Children
Under Age 18, By Family Income Level,
1986



Source: "Medicaid Source Book" - Congressional Research Service analysis of March 1987 CPS data.

million uninsured children are in the group below 150 percent of the poverty line.[11] While a substantial portion of these children live in families with an employed adult, the marginal nature of much of this employment and the numbers without employment indicate the need to continue relying on a broad public program for basic coverage of this segment of the population.

B. Financing Care for Catastrophically and Chronically Ill Children

There is only a limited amount of information on the role Medicaid plays in financing access to care for children with large health expenditures not covered by insurance.

One in every nine children in families with income above 200 percent of the poverty line is uninsured.[12] For these children, the absence of insurance is most likely a barrier to care only or primarily when chronic or major illness depletes the families' resources. Even for those with insurance, a chronic condition or catastrophic health event can be a financial problem because of lifetime limits, pre-existing condition exclusions, co-insurance requirements, and other restrictions on private insurance. In recent years, insurers have revised their policies to increase patient cost-sharing and restrict benefits.[13] Also, many employers have switched to self-insured health plans, which the federal ERISA law exempts from state laws mandating certain benefits in health insurance.[14] For example, all but two states require health insurance to cover newborns from birth without pre-existing condition restrictions.[15] However, self-insuring employers and union plans can and do decline to cover premature newborns and those with birth defects.[16]

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[11] "Medicaid Source Book," p. 332.

[12] "Medicaid Source Book," p.333.

Only a small fraction of the children above 200 percent of the poverty line are served by Medicaid, as shown in Exhibit IV-2. Seven-tenths of one percent have only Medicaid, while 0.5 percent have both Medicaid and other insurance.[17] This group is most likely composed of children who qualify for Medicaid under a variety of uncommon circumstances: children with very large medical expenses who qualify as medically needy "spend-downs" because of inadequate or no private insurance; technology dependent and other severely disabled children such as the mentally retarded, who qualify as institutionalized SSI eligibles or under Home and Community-based Care waivers; children in foster care and certain adoption-assisted children.

Disabled children, defined loosely as those with an activity limiting condition, are about as likely to be uninsured as non-disabled children, but are almost twice as likely to be covered by Medicaid or other public programs (25.4% vs. 14.2%).[18] Since the data do not include income, it is not possible to determine the extent to which the differences in public insurance are due to the fact that those poor children who already qualify for Medicaid also are more likely to have a disability. What is evident from the data is the fact that health insurance is lacking for a significant proportion of disabled children, who on average have higher health care expenses.

C. Patterns and Trends in Medicaid Expenditures and Utilization for Children

This section presents an examination of patterns and trends in Medicaid utilization and expenditures for children. It also contrasts their use with that of adult Medicaid beneficiaries.

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[13] "Health Insurance and the Uninsured: Background Data and Analysis," Congressional Research Service, Washington, D.C., May 1988, p. 20.

[14] From 1979 to 1987, the percent of large and medium employers with self-insured plans increased from 19 percent to 40 percent. Hay/Huggins Benefits Reports, as reported in "Health Insurance and the Uninsured: Background Data and Analysis," Congressional Research Service, Washington, D.C., May 1988, pp. 84-85.

[15] "State Mandated Health Care Coverage Laws (enacted through December, 1987)," Blue Cross and Blue Shield Association, Washington, D.C. January 1988.

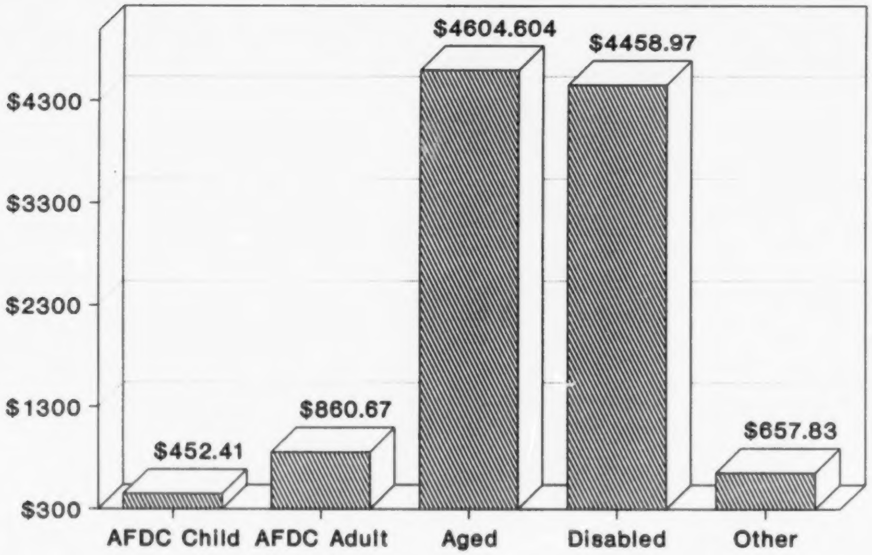
[16] Although national data on health insurance do not address specific exclusions, discussions with patient account managers in children's hospitals indicate that the problem is not uncommon. For example, see case history #4 in "Medicaid and Poor Children," p. 86.

[17] As noted earlier, those included in the "both Medicaid and other insurance" group may not actually have Medicaid coverage. Source: "Medicaid Source Book," p.333.

[18] Includes those with a combination of public and private coverage. Source: "Medicaid Source Book," p 333.

Exhibit IV - 3

Medicaid Expenditures Per Recipient by Basis of Eligibility - FY1985



Source: HCFA 2082 data.

1. Per Capita Medicaid Expenditures for Children and Adults

In general, children are the least expensive population group within Medicaid. In Federal Fiscal Year 1985, Medicaid spent $452 per AFDC child (under age 21), as compared to $860 per AFDC adult and over $4000 per aged and disabled recipient (see Exhibit IV-3).[19] Although most of the 10.3 million Medicaid recipients under age 21 fell within the AFDC category and had relatively low medical expenses, there is a small, but very expensive group of 544,047 children under age 21 comprised of the disabled and other

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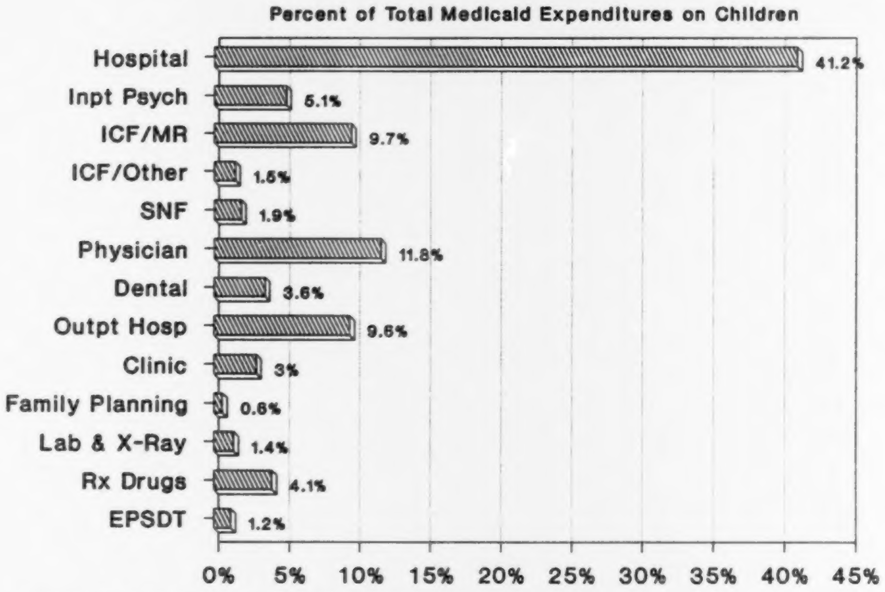
[19] These data tend to overstate per capita costs because the denominator includes only individuals who used one or more services in the year (i.e., recipients). Approximately 25 percent of Medicaid enrolled children use no services in the year. The AFDC, aged and disabled categories include both cash welfare and non-cash (Medicaid only, including the medically needy) recipients.

Unless otherwise noted, the data in this section were provided by HCFA and are from the HCFA 2082 form on which states report annual Medicaid "vendor payments" (expenditures) and recipients to HCFA.

Exhibit IV - 4

Distribution of Medicaid Expenditures for Children By Type of Service- FY 1985



Source: HCFA 2082 data for children under 21 years of age.

Medicaid recipients. Medicaid expenditures for these children averaged $5,162 per recipient per year.[20] The entire group of Medicaid children under age 21 averaged expenditures of $701 per recipient.

2. Distribution of Expenditures for Children

Institutional inpatient care accounts for more than half of all Medicaid spending on children. As shown in Exhibit IV-4, 41.2 percent of all Medicaid expenditures for children went for inpatient hospital care, while intermediate care facilities (ICFs) for the mentally retarded and others, skilled nursing facility (SNF) care and inpatient psychiatric care combined for another 18.2 percent. Physician services and hospital outpatient care accounted for 11.8 and 9.6 percent of total Medicaid expenditures on children, respectively. Prescription drugs and dental care each accounted for less than five percent of the total. Preventive and related treatment services under the EPSDT program comprised only 1.2 percent of Medicaid spending on children.

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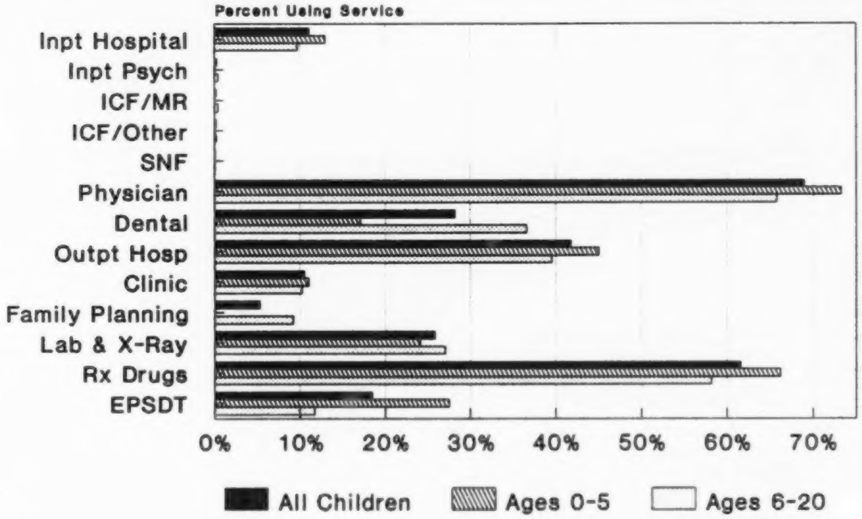
[20] This group most likely consists of a mix of expensive institutionalized children, such as the mentally retarded and developmentally disabled, along with refugees and "Ribicoff" (non-dependent) children.

Exhibit IV - 5



Service Use by Medicaid Children:
Users as a Percent of Total Recipients
by Service and Age Group - FY 1985

Source: HCFA 2082 data for children under age 21.

3. Medicaid Children's Utilization by Type of Service

Hospital and other inpatient services are used by a relatively small portion of Medicaid children, even though they account for a major share of expenses. Only one in nine Medicaid recipient children received hospital inpatient care (11.1%), as shown in Exhibit IV-5. The average Medicaid payment per inpatient hospital care recipient was $2606.

Other types of institutional inpatient care are used by very few Medicaid children. A total of eight-tenths of one percent of Medicaid children were inpatients of an ICF, SNF or psychiatric hospital. However, these services tend to be quite expensive: $29,182 per recipient of care in an ICF for the mentally retarded; $13,466 per inpatient psychiatric care recipient; $11,936 per SNF recipient; and, $6,729 per other ICF user. Although data were not available giving service use for children by basis of eligibility, it is very likely that the children using these other types of institutional inpatient services are SSI disabled beneficiaries.

Physician services and prescription drugs are the services most frequently used under Medicaid by children. Sixty-nine percent of recipients were seen by a physician, while 61.6 percent received one or more prescription drugs.[21] Annual Medicaid spending per child receiving physician care averaged $120, while per user prescription drug costs averaged $47.

Outpatient hospital care plays a prominent role in the utilization of services by Medicaid children. Hospital outpatient departments and emergency rooms were used by 41.8 percent of Medicaid recipient children, at a cost to Medicaid of $161 per user per year.

Hospital outpatient care serves a dual role for Medicaid children. It is the primary source of access for many Medicaid children, as well as a source of specialized care. The hospital outpatient department or emergency room was cited as the usual source of care for 24.0 percent of Medicaid children in a 1977 survey, more than double the proportion for privately insured children.[22] The case mix complexity seen by hospital-based pediatric practitioners is greater than that seen by pediatricians in private practice, most likely a reflection of the role the outpatient department plays in delivering specialized care.[23]

Over one-quarter of Medicaid children received dental care (28.2%) and laboratory or X-ray services (25.8%). Ten percent used the services of free-standing clinics and 5.3 percent of the age group under 21 received family planning services.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides basic preventive care and well child services. There is tremendous variability from state to state in the use of EPSDT. In the average state, 17.9 percent of Medicaid children were seen in an EPSDT program in 1985.[24] Although in eight states the use rate exceeded 30 percent, there were 12 states where less than ten percent of the children received EPSDT services. The average Medicaid expenditure on EPSDT per user was $45.

4. Utilization and Expenditure Patterns of Medicaid Children by Age Group

There are several striking differences in the Medicaid expenditures and use pattern for young children under age six as compared to older children in the age group 6 through 20. Although the younger children were more likely to use specific services (as shown in Exhibit IV-5), the older age group was 14 percent more expensive, with expenditures per recipient averaging $740.41 versus $648.41 for the group under age 6.

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[21] Since only about 75 percent of children enrolled in Medicaid are recipients, the percent of children enrolled in Medicaid who see a physician is close to 50 percent.

[22] Kasper, Judith D., "The Importance of Type of Usual Source of Care for Children's Physician Access and Expenditures," HCFA Office of Research, based on a presentation at the American Public Health Association annual meeting, Dallas, TX, November 1983, Table 8.

[23] Lion, J. et al, "A Comparison of Hospital Outpatient Departments and Private Practices," HCFA Review, Vol. 6, No. 4, Summer 1985.

[24] Fiscal year 1987 EPSDT participation data reports (HCFA 420 forms) indicate that the ratio of the number of EPSDT screening examinations to Medicaid eligible children, expressed as a percentage, equaled 29.6 percent. (Source: "Medicaid Source Book," p. 323.) It is not known whether the difference in use rates reflects multiple exams for some individuals or a significant increase in use over the two years. Expansions in Medicaid eligibility for infants, combined with the higher frequency of well child visits for infants, could have produced an increase in the average use rate.

The younger group was one-third more likely to use hospital inpatient care (13.0% versus 9.7%), probably a reflection of a large number of hospital births in the under age six group.[25] Similarly, hospital payments accounted for a larger portion of total expenses on the younger age group: 54.8 percent versus 32.3 percent.

Young children were almost three times as likely to receive EPSDT services as the group age six and older. Over one-quarter (27.5%) of the group under age six were served by the EPSDT program, compared to only 11.7 percent of those over age 5. Younger children are also slightly more likely to see a physician (73.3% versus 65.8%) or receive hospital outpatient care (45.0% versus 39.5%).

Children in the age group 6 through 20 were almost four times as likely to receive inpatient care in an ICF, ICF/MR, SNF or psychiatric facility as a child under age six. Although these services are used by only 1.1 percent of the recipients ages 6-20, they account for over one-quarter (27.4%) of all Medicaid expenditures for this group of children.

As might be expected, the older group of children were more likely to use dental care. Over one-third (36.6%) of the children age six and older received dental care, compared to 17.1 percent for the group under age six.

5. Recent Trends in Medicaid Expenditures and Service Delivery for Children and Adults

During the 1980s, several trends developed in the Medicaid program that have significant implications for children's access to health care. During the first half of this decade, three key Medicaid trends resulted from the federal and state governments' fiscal austerity and the economic recession of 1982. First, Medicaid eligibility levels failed to keep pace with inflation and the growing number of poor children. Second, restrictions on reimbursement and service coverage produced a decline in real health care purchasing power for Medicaid children. Third, states implemented a variety of new managed care approaches to service delivery for Medicaid children. As the decade draws to a close, only the first trend appears to be abating, largely through eligibility reforms for pregnant women and young children enacted by the Congress and adopted by many of the states (see discussion in Section IV-D).

a. Declines in Medicaid Eligibility for Children

From 1980 to 1985 Medicaid eligibility for children failed to keep pace with inflation and growth in the numbers of poor children. During this period, the number of children living in poverty grew by 13.1 percent, but the number of children served by Medicaid grew by only 2.5 percent.[26] Thus, the ratio of Medicaid children to poor children declined by 9.4 percent. Put in terms of total children served by Medicaid, the decline represents more than one million poor and medically needy children loosing Medicaid coverage.[27]

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[25] These data probably under-report hospital use by newborns, since some hospitals include the charge for the newborn on the mother's bill and some states may pay separate charges for the newborn under the mother's Medicaid ID.

[26] Brian Burwell and Marilyn Rymer, "Trends in Medicaid Eligibility: 1975 to 1985," Health Affairs, Winter 1987.

[27] "Medicaid and Poor Children," p. 8.

One key factor in the loss of Medicaid eligibility was an Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) provision reducing AFDC eligibility which immediately removed over 600,000 children in low income working families from the Medicaid rolls.[28] The failure of states to raise their AFDC eligibility levels in pace with inflation is another factor.

b. Declining Medicaid Purchasing Power for Children's Health Care

Children have been disproportionately affected by the Medicaid cost containment efforts of the early 1980s. States were impelled to contain their spending by an OBRA 1981 provision that established penalty reductions in federal matching funds for states which did not adequately control growth in Medicaid spending in fiscal years 1982-85. Accompanying provisions of OBRA 1981 were intended to give states greater flexibility in their Medicaid programs in order to achieve the savings needed to avoid the penalties. These included provisions which allowed states to provide a lesser service coverage package for the medically needy, discontinue cost-related reimbursement rates, restrict beneficiaries' freedom of choice of provider, and implement capitated care programs.

One impact of states' Medicaid cost containment efforts in response to OBRA 1981, according to an Urban Institute study, was that "children [and AFDC adults] bore the brunt of state efforts to control Medicaid acute care services."[29] Medicaid spending per capita for AFDC children declined by 9.3 percent in constant dollars from 1981 to 1984, while per capita spending for the elderly and disabled increased by 9.3 and 5.7 percent, respectively (see Exhibit IV-6). Over the six year period from 1978 to 1984, the Medicaid purchasing power of children declined by 14.4 percent, while for the elderly and disabled it increased by 28.8 and 23.4 percent, respectively.

The principal reason why AFDC children and adults were disproportionately affected is that Medicaid cost containment efforts were directed at the acute care services upon which these groups are most dependent. For example, real spending per Medicaid child for physician care declined by 5.1 percent and dental care by 9.0 percent from 1981 to 1984. These reductions "were due to severe fee restraints imposed by a large number of states and probably to reductions in physician participation and accompanying drops in use of physician services."[30] The period also witnessed the growth of Medicaid prospective payment systems for hospital inpatient and outpatient care, the expansion of direct limits on utilization and more intensive use of prior authorization to control hospital use, according to the Urban Institute study. Since the elderly and disabled generally rely upon Medicare as the primary payor for these services, they were less affected by Medicaid's focusing its cost containment on acute care services.

c. Delivery System Reforms

The third important Medicaid trend of the 1980s was a growing interest in delivery system reform. Many states sought to contain costs and improve services through primary care case management (with and without capitation payments) using the flexibility of "waivers" authorized by Section 2175 of OBRA 1981 and through other Medicaid provisions allowing contracting with managed care systems, such as

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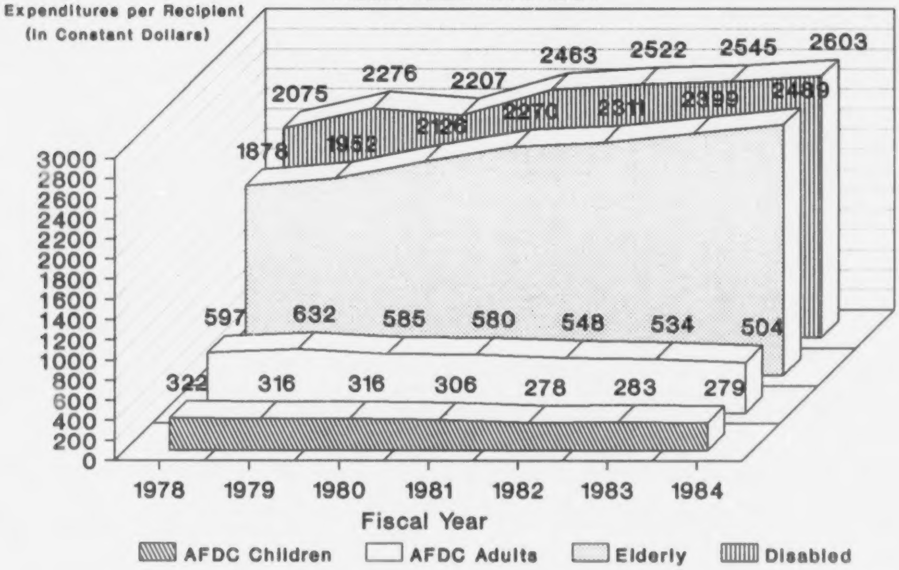
[28] U.S. House of Representatives, "Impact of Budget Cuts on Children," WMCP 97-30, GPO, Washington, D.C., March 1982, p. 3.

[29] John F. Holahan and Joel W. Cohen, "Medicaid: the Trade-off between Cost Containment and Access to Care," The Urban Institute Press, Washington, D.C., 1986, p. 52.

[30] Ibid., p. 73.

Exhibit IV - 6

Trends in Medicaid Expenditures per Recipient
in Constant Dollars, by Basis of Eligibility
Fiscal Years 1978-1984



Source: Analysis of HCFA 2082 data by John Holahan and Joel Cohen, "Medicaid: The Trade-Off Between Cost-Containment and Access to Care," Urban Institute Press, 1986.

health maintenance organizations (HMOs), prepaid health plans (PHPs), and health insuring organizations (HIOs).[31]

The interest of Medicaid programs in managed care systems (eg., HMOs, PHPs, and HIOs) and in primary care case management stems from the widely held perception and substantial research showing that Medicaid beneficiaries inappropriately rely upon the emergency room (ER) for non-urgent and primary care.[32] Use of the ER as the usual source of care by Medicaid and low income uninsured populations is thought to be due to a variety of factors, including an inadequate supply of primary care physicians willing to accept Medicaid and uninsured patients and the availability of care 24 hours per day, seven days a week.[33] Inappropriate use of ERs for primary care is of concern to Medicaid because the care is more expensive than similar care in a private practitioner's office, may lead to a higher rate of hospitalization, and results in episodic treatment, often with insufficient follow-up care.

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[31] Another delivery system reform option, Section 2176 of OBRA 1981, led most states to develop one or more home and community-based alternatives to institutional long-term care for the elderly, mentally retarded, and/or physically disabled. Since few of these programs were designed specifically for children, alternatives to long-term care are not included in the discussion of delivery system reforms.

[32] Robert E. Hurley, Deborah A. Freund and Donald E. Taylor, "Emergency Room Use and Primary Care Case Management: Evidence from Four Medicaid Demonstration Programs," American Journal of Public Health, Vol 79, No. 7 (July 1989), p. 843.

As of 1987-88, 32 state Medicaid programs had operational managed care contracts and/or primary care case management programs.[34] In general, these programs are intended to contain costs and enhance continuity of care by paying for health care services only when authorized by the Medicaid patient's primary care case manager (usually a physician) or health plan. Many of the programs provide financial incentives to the care manager or plan to reduce ER use, referrals, and hospitalization. In nine of the states, enrollment in managed care is mandatory for some or all categories of Medicaid beneficiaries. Even in the programs with voluntary enrollment, there are concerns about whether the Medicaid enrollees sufficiently understand that they are giving up their freedom of choice and must receive an authorization from the care manager before seeking care elsewhere.

For hospitals, a major concern about managed care relates to shifting the "gatekeeper" responsibility from the care manager to the ER in the case of patients presenting themselves for unauthorized non-emergency care at the ER. At a minimum, the ER must examine each patient seeking care because of legal requirements (eg., federal "anti-dumping" provisions), as well as malpractice and ethical concerns, even though the case manager may not have pre-authorized the visit. If the case manager can be contacted by the ER following the initial assessment, but declines to authorize treatment, there is no payment to the hospital for the examination which it has already performed. Furthermore, it falls to the ER to inform the patient that treatment has not been authorized and to deal with hostile and belligerent patients who nonetheless demand treatment. Hospital ERs have been reported to have "expressed great reluctance to deny care to on-site patients for whom authorization could not be obtained."[35]

A recent study examining the first year impact of four Medicaid case management programs on ER use by children found reductions of 27.5 to 36.7 percent in the proportion using the ER.[36] The authors found the magnitude of the drop surprising in view of the limited time for learning effects and the fact that hospitals were reluctant to turn patients away. Since the study used paid claims to measure use, it is entirely plausible that use patterns were largely unchanged and that as many as one-third of the ER visit claims were rejected and not paid because the care was not authorized by the care manager. A related study of six "mature" Medicaid managed care demonstrations found that the programs generated savings to Medicaid, but that the savings were "minuscule" in relation to expenditures for acute care.[37] Nonetheless, Medicaid officials perceived the programs' benefits in delivery system reform and continuity of care to be worth the major effort it took to establish the programs even were there no cost savings.

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[33] Steven Davidson, "Understanding the Growth of Emergency Department Utilization," Medical Care, Vol. 16, No. 1 (January 1978), p. 122-132.

[34] Note: includes the Arizona demonstration Medicaid program. Source: "Medicaid Source Book," pp. 155-156 and pp. 427-428.

[35] "Emergency Room Use and Primary Care Case Management," p. 845.

[36] Ibid., p. 845.

[37] "Evaluations of Recent Changes in Medicaid," p. 178.

d. Future Trends

Although Medicaid interest in cost containment and managed care continues to be strong, public reactions to the sharp losses in Medicaid eligibility in the early 1980s are probably responsible for the considerable attention devoted in the second half of the 1980s to the structural shortcomings of Medicaid eligibility and the need to improve access to Medicaid and to health care for pregnant women and children. These structural and access problems and the reforms enacted over the period 1984-88 are discussed in the next section.

D. Breaking the Medicaid - Welfare Linkage

Why is Medicaid a severely inadequate health care financing program for poor children and those with large uninsured expenses? The simple answer is that Medicaid eligibility has historically been closely linked to eligibility for cash assistance welfare.

The specific reasons why Medicaid has not reached the one-third of our poor (and near poor) children in need of health care coverage and why even Medicaid enrolled children have problems accessing needed care are:

- The failure of states to raise AFDC eligibility levels in pace with inflation.
- The fact that 15 states have not elected to operate medically needy programs, as of July 1987.
- The federal law limiting medically needy income thresholds to 133 percent of the AFDC level, which combined with low AFDC levels and no medically needy programs, results in the exclusion of children above 55 percent of the federal poverty level in the average state.[38]
- Complex AFDC/Medicaid application and documentation requirements that result in one-quarter of all applicants being denied, not because of ineligibility, but because they could not complete the application process.[39]
- Inadequate information on the differences between welfare and Medicaid eligibility and the stigma of welfare deter eligible families from enrolling in Medicaid.
- The failure of 10 states to elect AFDC and Medicaid options to include all non-dependent children (as of December 1986), thus denying Medicaid to children, no matter how poor, solely because they are fortunate enough to live in a two-parent household.

There are also problems specific to Medicaid that limit its effectiveness as a safety net:

- Few states provide children unlimited access to all the services they need.

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[38] Of course in medically needy program states, children from higher income families can qualify after spending-down.

[39] Applications denied for procedural reasons and applications withdrawn in the period July 1, 1985 through June 30, 1986 involved 2.3 million of the 9.7 million individuals included in applications for the period. Source: Sarah C. Shuptrine and Vicki C. Grant, "The Relationship Of The Reasons For Denial Of AFDC/Medicaid Benefits To The Uninsured In The United States," Sarah Shuptrine & Associates, Columbia, S.C., October 1988.

- Low provider payment rates undercut active participation and lead to access problems for Medicaid children.
- Inadequate promotion of EPSDT preventive services resulting in less than 30 percent of eligible children being screened in 1987.[40]
- Inadequate access to care under the medically needy program because families must depend on health providers to treat them on "faith" with the presumption that when the bills are big enough they will qualify for Medicaid.
- Inadequate protection against medical indigence due to unlimited spend-downs that require families to become truly impoverished as a condition of medical assistance.
- Few states have used the Home and Community-based Care option to overcome the SSI institutional care bias and allow technology-dependent and other physically disabled children to receive appropriate care at home.[41]

The inadequacies of Medicaid are painfully obvious when the policies of individual states are examined. For example:

- Alabama excludes children from Medicaid if families income exceeds 14 percent of the federal poverty level.
- Kentucky's Medicaid program will generally not cover hospital stays longer than 14 days.
- New Hampshire pays a physician only $15 to perform a comprehensive physical exam on a child.
- New Jersey pays only $7 for a follow-up office visit.
- Arkansas, Delaware, Indiana, Kentucky, and Wisconsin provided EPSDT to less than 10 percent of eligible children in 1987.

In the past few years, particularly under the 100th Congress, legislation has been passed to address some of the key deficiencies in Medicaid. The most important provisions have been aimed at:

- Delinking Medicaid from welfare cash assistance in terms of both income limits and categorical-relatedness.
- Making Medicaid a more uniform program in terms of eligibility.
- Making the application process simpler, more accessible, and faster.

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[40] The 30 percent rate is most likely an overestimate of the percent of children receiving EPSDT services. The number is actually the ratio of EPSDT screening examinations to Medicaid eligible children, based on the HCFA 420 form. HCFA 2082 data on the number of unduplicated EPSDT recipients in 1985 yields a rate slightly over half as large. Source: "Medicaid Source Book," p. 323.

[41] A majority of states have used the waiver authority to serve the elderly and the mentally retarded.

- Improving access by assuring more adequate service coverage and payment for infants served in disproportionate share hospitals.

The improvements in income eligibility thresholds for children and pregnant women are displayed graphically in Exhibit IV-7. The specific Medicaid improvements include:

- Legislation passed in 1984, 1986, and 1987 requiring states to cover all children below the state AFDC welfare income level regardless of family structure - but only up to age 7.
- OBRA 1987 gave states the option to phase in Medicaid eligibility for children up to age 8 who live in families with incomes below the federal poverty level.
- OBRA 1987 gave states the option to provide Medicaid to pregnant women and infants with incomes up to 185 percent of the federal poverty level.
- The 1988 Medicare Catastrophic Coverage Act mandated Medicaid coverage of all pregnant women and infants below 100 percent of poverty by July 1990. It also required states to drop limits on hospital stays and to pay adequately for exceptionally long and costly stays, but only for infants in disproportionate share hospitals.
- The 1988 welfare reform legislation further expands Medicaid by permitting families to stay on Medicaid for up to one year after leaving welfare because of employment and allows Medicaid to purchase employer offered health insurance.[42] It also mandates Unemployed Parent Medicaid coverage for two parent families with incomes up to the state-set AFDC income levels.

The new eligibility options for pregnant women and children up to age 8 also include features to speed Medicaid enrollment and foster immediate and continuous access to care. States may eliminate the asset test, which considerably simplifies the application form and verification process.[43] For pregnant women, presumptive eligibility is also permitted so that a Medicaid card can be issued on the basis of the application, rather than several weeks or months later as usually happens. A related feature allows certain health providers to conduct Medicaid enrollment on-site for pregnant women, eliminating the need for applicants to access Medicaid through the welfare offices.

Exhibits IV-8 and IV-9 display the status of state adoption of the new Medicaid options as of July 1989. As is evident, the states have responded vigorously to the opportunity to broaden Medicaid eligibility for children and pregnant women. Forty-five states raised Medicaid eligibility thresholds to 100 percent of poverty or higher for pregnant women and infants up to age one, with about half employing the presumptive eligibility option for pregnant women. Thirty-eight states chose to increase income thresholds for young children to 100 percent of the poverty line, with half offering expanded eligibility

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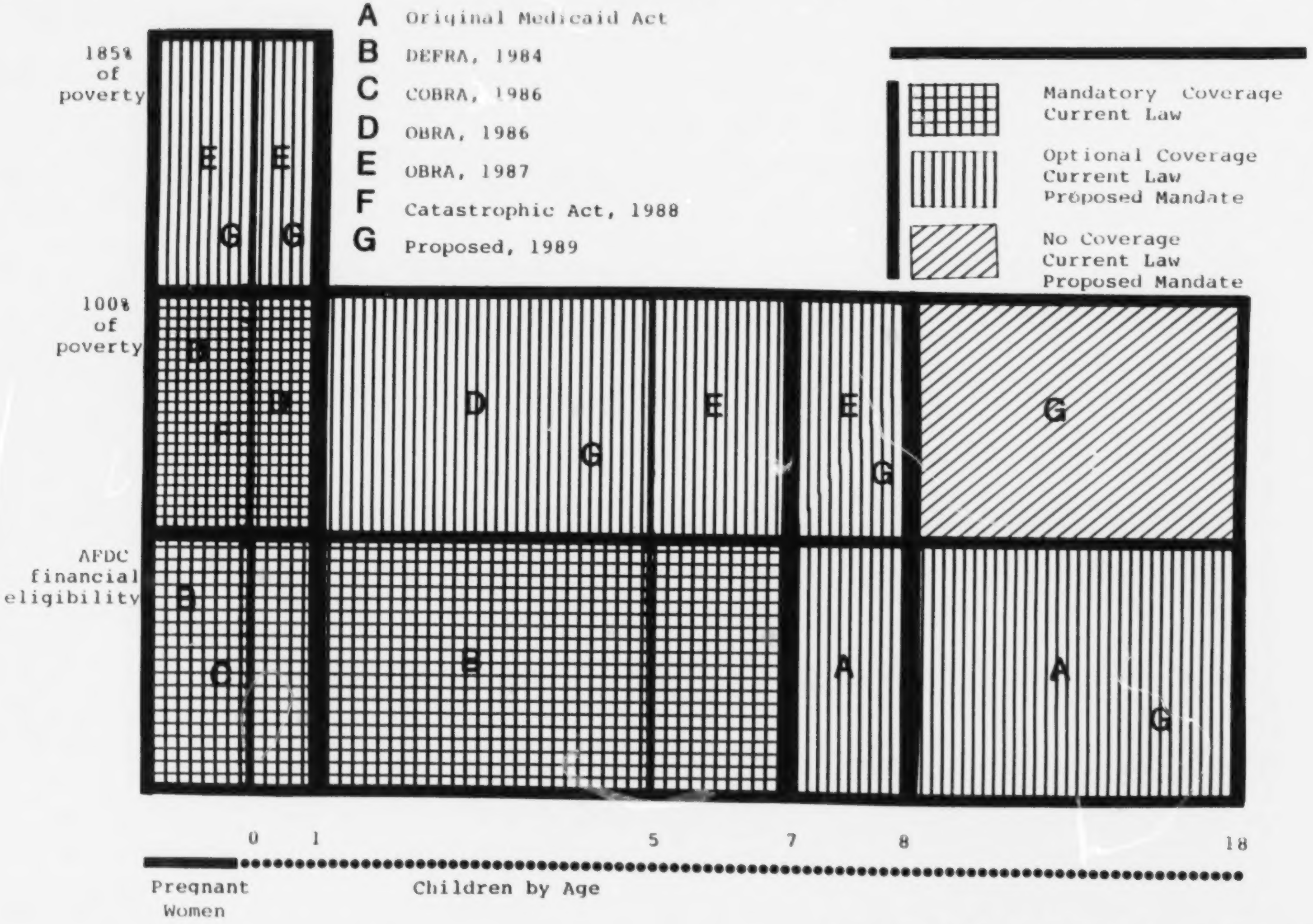
[42] Under this provision, the state can elect to provide those Medicaid covered services which are not included in the employer's insurance package, as well as cover the deductibles and coinsurance required by the employer's insurance.

[43] For example, West Virginia was able to reduce the application from 14 pages to four.

Exhibit IV - 7

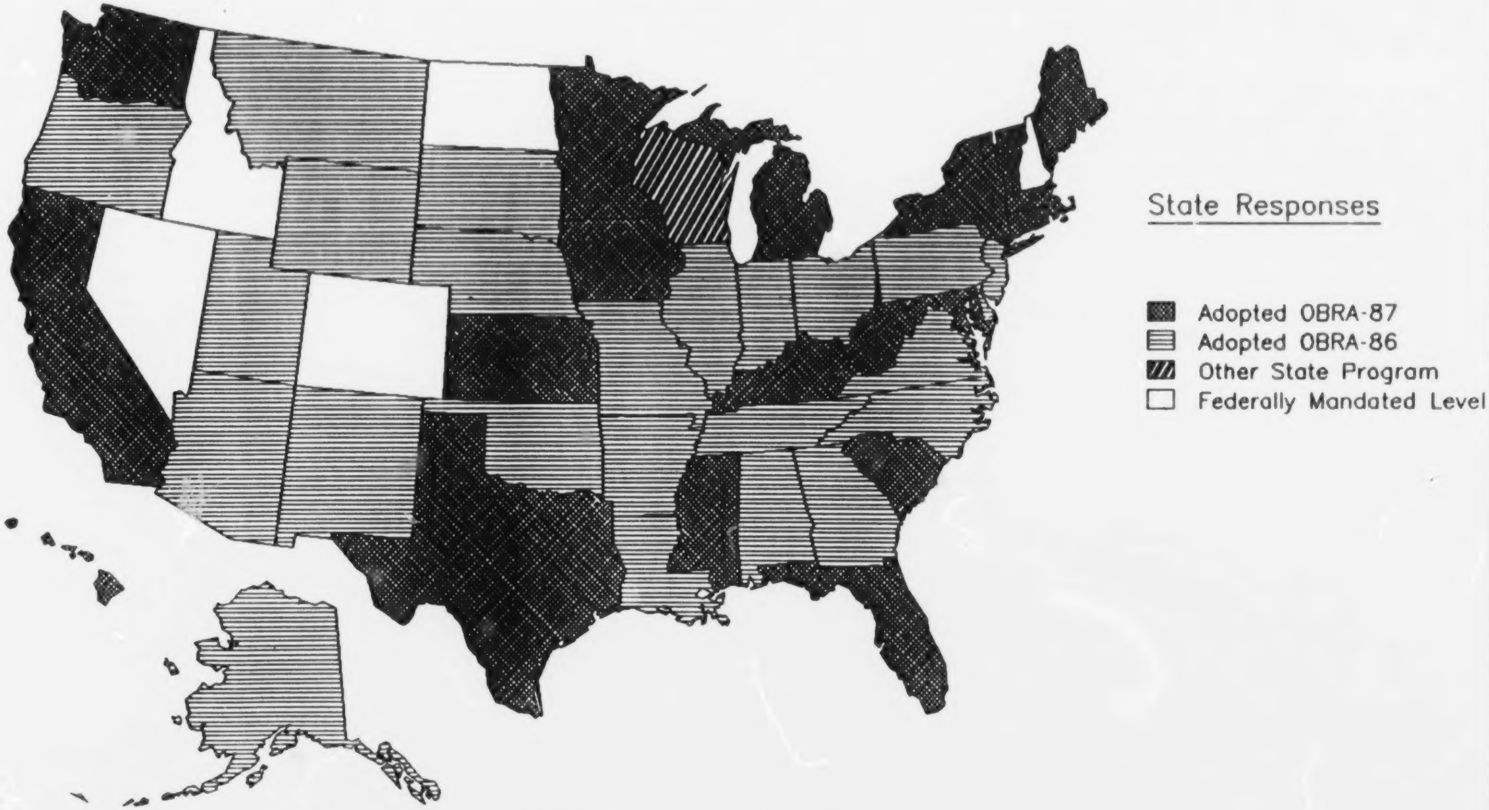
Medicaid Coverage of Pregnant Women and Children



Prepared by Children's Defense Fund, 1989

Exhibit IV - 8

STATES BROADENING MEDICAID ELIGIBILITY
Coverage of Pregnant Women and Children Up To/Above Poverty
July 1989


State Responses
▦ Adopted OBRA-87
▤ Adopted OBRA-86
▨ Other State Program
☐ Federally Mandated Level

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

Exhibit IV - 9

OBRA - '86/'87 SUMMARY STATUS

COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF JULY 1989

	PREGNANT WOMEN AND INFANTS PERCENT POVERTY	OLDER CHILDREN COVERED UNDER POVERTY TO AGE		DROPPED ASSETS TEST	CONTINUOUS ELIGIBILITY	PRESUMPTIVE ELIGIBILITY	ORIGINAL EFFECTIVE DATE
		2 - 4	5 - 8				
Alabama	100			X	X	X	7/88
Alaska	100	X		X	X		1/89
Arizona	100		X	X	X		1/88
Arkansas	100		X	X	X	X	4/87
California	185						7/89*
Colorado	75**					X*	7/89
Connecticut	185			X	X		4/88
Delaware	100	X		X	X		1/88
DC	100	X		X	X		4/87
Florida	150		X	X	X	X	10/87
Georgia	100	X		X	X		1/89
Hawaii	185*		X	X	X	X	1/89
Idaho	75**			X	X	X	1/89
Illinois	100				X	X	7/88
Indiana	100	X		X	X	X	7/88
Iowa	185		X		X	X	1/89
Kansas	150		X	X			7/88
Kentucky	125	X			X		10/87
Louisiana	100		X	X	X	X	1/89
Maine	185		X	X		X	10/89
Maryland	185	X		X	X	X	7/87
Massachusetts	185		X	X	X	X	7/87
Michigan	185	X		X	X		1/88
Minnesota	185		X	X	X		7/88
Mississippi	185		X	X	X		10/87
Missouri	100	X			X		1/88
Montana	100			X			7/89
Nebraska	100	X		X	X	X	7/88
Nevada	75**		X	X			7/89
New Hampshire	75**			X			7/89
New Jersey	100	X		X	X	X	7/87
New Mexico	100	X		X	X	X	1/88
New York	185			X	X	X	1/90*
North Carolina	100	X		X	X	X	10/87
North Dakota	75**						7/89
Ohio	100			X	X		1/89
Oklahoma	100	X		X	X		1/88
Oregon	85	X		X	X		11/87
Pennsylvania	100	X		X		X	4/88
Rhode Island	185		X	X	X		4/87
South Carolina	185		X	X	X		10/87
South Dakota	100	X		X	X		7/88
Tennessee	100		X	X	X	X	7/87
Texas	130	X			X	X	9/88
Utah	100			X	X	X	1/89
Vermont	185		X	X	X		10/87
Virginia	100	X		X	X		7/88
Washington	185		X	X	X		7/87
West Virginia	150		X	X	X		7/87
Wisconsin	***					X	4/88
Wyoming	100		X	X	X		10/88
TOTAL	45	19	19	42	41	23	

* FUTURE IMPLEMENTATION DATE

** COMPLIANCE WITH MINIMUM MANDATED COVERAGE

*** STATE FUNDED PROGRAM COVERS PREGNANT WOMEN AND INFANTS BELOW 120% OF POVERTY

SOURCE: NATIONAL GOVERNORS' ASSOCIATION - JULY, 1989 to children up to age eight and half limiting it to children with ages two through four.[44] Forty-one states elected to drop asset tests for the new eligibles.

The legislation also reflects a growing recognition that simply expanding eligibility thresholds and easing the application process is not enough to assure improved access to health care services. To effect access, there also needs to be adequate covered benefits and adequate reimbursement to providers. Included in OBRA 1987 are expanded requirements for Medicaid payments to hospitals with a disproportionate share of Medicaid patients. In the 1988 Medicare Catastrophic bill there is a new requirement for states to lift arbitrary coverage and payment limits on inpatient services for infants in hospitals with high Medicaid loads.

The use of a nationally uniform Medicaid income threshold for infants and pregnant women in the Medicare Catastrophic Coverage Act is a precedent-setting landmark. However, it also reflects a continuation of disparity in the protection given to children and the elderly. The mandate covers children only up to one year of age. In contrast, the same act mandates that Medicaid purchase Medicare supplemental insurance and provide Medicaid wrap-around coverage of Medicare-covered services for all elderly below the poverty line. Furthermore, the law retains the inadequate AFDC asset test for children, but for the elderly sets the asset threshold at twice the already more liberal SSI level. Finally, the law sets a protected income provision for spouses of institutionalized SSI Medicaid eligibles that limits the spend-down amount, while medically needy families continue to be impoverished.

These incremental improvements in Medicaid for children and pregnant women are critical steps towards needed reform. They will extend Medicaid to hundreds of thousands of poor children among the over four million poor children who as of 1986 lacked health coverage. However, these improvements and the disparity with the protection afforded the elderly only point the way to the reforms needed to make Medicaid an effective social safety net -- they do not resolve them.

Concern is now being expressed regarding how these Medicaid expansions will be financed. A portion will likely come from Medicare's assumption of catastrophic expenses which have heretofore been borne by Medicaid. In the past, provider reimbursement levels and service benefits have been targeted as the means of controlling total Medicaid outlays. Many states are concerned about how they will finance mandatory expansions. With payment rates already woefully inadequate for many providers, it seems evident that access for additional poor persons can not be achieved by having providers financing the expansion.

E. Closing the Remaining Gaps

A variety of proposals have been introduced in the 101st Congress to address the gaps which remain. A number of steps need to be taken, of which many, but not, all are addressed in the proposed legislation. To close the remaining gaps and make Medicaid a truly effective means of investing in the health of this nation's children, several major steps are needed:

o Medicaid eligibility needs to be expanded to all poor children over age one (who are below the federal poverty level) and to the near poor children - who together make up half of all uninsured children. Asset tests need to be eliminated or liberalized. Immediate access to care for eligible children needs to be assured through presumptive eligibility and enrollment at sites other than welfare offices.

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[44] Expansion to age eight is being phased-in, as this optional expansion applies only to children born after September 30, 1983.

- Medicaid needs to be expanded to cover children whose catastrophic health care costs threaten to drive young families into poverty by making the medically needy program mandatory and capping family out-of-pocket costs at a reasonable percent of income.
- Medicaid SSI eligibility for technology-dependent and other disabled children needs to be continued outside institutions in all states.
- Medicaid needs to establish more effective enrollment of eligible families, which means better informing, of eligible families reducing the bureaucratic barriers in the application process, and compensating the states for their efforts to implement these options and mandates.
- Medicaid needs to assure actual and ample access to necessary health care services through adequate service coverage for children enrolled in Medicaid and adequate reimbursement to the providers who serve them.

Chapter V

Role of Children's Hospitals and Special Issues of Pediatric Disproportionate Share Providers

Introduction

This chapter examines the unique role and characteristics of children's hospitals, particularly the role they play in serving children from low income families and those with special health care needs. This chapter also examines the special issues associated with being a pediatric disproportionate share provider.[1]

The highlights of this chapter include the following observations and findings:

- Children's hospitals provide a disproportionate share of their services to Medicaid and poor patients compared to other hospitals:
  - Almost three-quarters of children's hospitals provide over 20 percent of their patient days to Medicaid patients. Only one in five public general hospitals and one in ten non-profit general hospitals reach this level of service to Medicaid patients.
  - Medicaid patients account for 25.6 percent of the admissions and 28.9 percent of the inpatient days in the average acute care children's hospital.
  - Medicaid patients account for 33.7 percent of emergency room visits, 31.5 percent of clinic visits, and 21.1 percent of ambulatory surgery in the average acute care children's hospital.
- Acute care children's hospitals provide almost 30 percent more uncompensated care (charity and bad debt) than the average general hospital - 8.3 percent versus 6.4 percent.
- Compared to non-Medicaid children, the Medicaid inpatients:
  - Are younger in age;
  - Are hospitalized for different illnesses;
  - Stay longer on average for a given diagnosis;
  - Have a higher proportion with exceptionally long lengths of stay for a given diagnosis, indicating greater severity of illness;
  - Are more likely to have a catastrophic illness.
- Medicaid children with congenital, chronic, or other conditions which require specialized care tend to be concentrated in children's hospitals or general teaching hospitals.

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[1] The term disproportionate share provider is used here in its generic sense, connoting a significantly higher than average load of Medicaid and uncompensated care (eg. charity and bad debt) patients. It is not intended to imply designation of disproportionate share status under the various criteria used by Medicare and the state Medicaid programs.

- Disproportionate share hospitals are more vulnerable to inadequate Medicaid payment and are disadvantaged in competition for adequately financed patients compared to hospitals with lower proportions of Medicaid and unsponsored patients.

A. Unique Role of Children's Hospitals

Children's hospitals play an essential role as centers of excellence in providing a wide array of primary, secondary and tertiary health care services to children. They also are essential institutions in the graduate medical education of pediatricians and pediatric specialists. Virtually all of the acute care children's hospitals are primary pediatric residency training sites. Approximately 25 percent of all U.S. pediatric residency positions and a higher percentage of pediatric fellowship positions (eg, pediatric cardiologists, pediatric neurologists, neonatologists) are in children's hospitals. In addition, many internal medicine, surgical and other physician residents get their pediatric training through rotations at children's hospitals. In this regard, children's hospitals are essential not only to the care of children today, but also to the future supply of health care for children.

As part of their mission of serving all children, children's hospitals maintain a strong commitment to serving poor children. The result is that children's hospitals serve a disproportionate number of Medicaid children and children with inadequate or no insurance who are unable to pay. Over one-third of the resources of children's hospitals are devoted to care for poor children, as measured by the sum of gross revenue (charges) associated with Medicaid, charity, and bad debt.[2]

As disproportionate share providers, children's hospitals serve a mix of children who are different from those seen in community hospitals. The children seen as inpatients in children's hospitals are sicker, have more complex illnesses, and stay longer than children seen in other hospitals. Specialized inpatient and outpatient care for certain congenital, chronic, and acute illnesses of children is concentrated in or available only from children's hospitals. In this regard, children's hospitals are essential to the care of certain children for whom there are few or no other care alternatives.

In addition to serving as centers of excellence for training in pediatric medicine and surgery, children's hospitals are also centers of research and development in the care of children. Children's hospitals have led the way in the development of vaccines, medicines, surgery, and other treatments for children, including the Sabin polio vaccine, and neonatal intensive care of premature newborns. They have also led the way in defining architectural and programmatic requirements for the care of children in hospitals. Because children are not little adults, their care and the physical environment in institutions needs to reflect different requirements for activity, play, physical and mental development, and education.

The philosophy of the children's hospital is also distinct from that of many other institutions. The children's hospital is, first and foremost, an advocate for the health of children in the broadest sense, encompassing the physical, emotional, and social well-being of children. Because children grow, thrive, and heal best in the home environment, it is the decided thrust of children's hospitals to provide inpatient care only when other alternatives are not in the best interests of the child and to arrange discharge at the earliest possible moment. Children's hospitals emphasize prevention, continuity of care, and education of parents and children to be active participants in both good health practices and the treatment of significant illness.

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[2] "Highlights of Children's Hospitals Patients, Services, and Finances," NACHRI, Alexandria, Virginia, September 1988, p. 29.

B. Special Issues of the Pediatric Disproportionate Share Provider

Children's hospitals are major disproportionate share providers. In serving large numbers of Medicaid patients as well as uninsured and underinsured patients (approximately 35 percent of their total patients), children's hospitals face the special financial problems of a disproportionate share provider. Disproportionate share providers are defined by the Healthcare Financial Management Association as institutional health care providers who, in comparison to the average provider, make available a significantly greater volume of services which are either uncompensated or that result in a payment shortfall.[3] According to this definition, "payment shortfall" refers to payments which are less than the full economic cost of the services, but only in "those situations which are mandated by legislation, regulation or economic circumstances."[4] Payment shortfalls in Medicaid (and Medicare) reflect the fact that payment amounts are "increasingly set in relation to constraints on the government's budget and not in relation to the beneficiaries' needs for services or the economic costs of the services provided."[5]

Traditionally, hospitals have dealt with the problems of uncompensated care and under-compensated care (payment level shortfalls) by shifting the unmet costs to charge-paying patients and to other sources.[6] The problem of being a disproportionate share provider is that a hospital's ability to cost-shift decreases as its portion of uncompensated and under-compensated patients grows.

Consider the following hypothetical example:

> If 20 percent of a hospital's patients receive uncompensated or under-compensated care and their payments cover only half the cost of care for this group, the hospital might try to recover these costs by charging the other 80 percent of patients an additional 12.5 percent. In actuality, the hospital would have to mark up charges by more than 12.5 percent because there are increasingly few payors who pay full charges. If 40 percent of the patients pay costs, as defined in Medicare-Medicaid cost principles, then the hospital would have to mark up charges by 25 percent.
>
> If the uncompensated and under-compensated group were to grow from 20 percent of the patients to 40 percent, then the hospital would have to increase charges to other patients by at least 33 percent, rather than 12 1/2 percent, to recover the losses on this group. If another 40 percent of the patients pay only cost, then the mark-up would rise to 100 percent.

Cost-shifting is also often used by general hospitals to subsidize the higher costs of pediatric care. Many hospitals are believed to charge the same room rate for pediatrics as for adult medical-surgical routine care, even though nurse staffing levels and direct costs per patient day are about 40 to 60 percent higher in general hospitals' pediatric units than their adult medical-surgical units.[7] Since adults outnumber children about 10-to-1, the added charge to adult room and board rates is only on the order of about five percent. However, children's hospitals do not have adult patients and are at a competitive price disadvantage relative to hospitals which can subsidize pediatric care through adult patient revenues.

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[3] "Definition of and Payment for Uncompensated Services and Special Problems of A Disproportionate Share," Healthcare Financial Management Association, 1987, Oak Brook, Illinois, p. 11.

[4] Ibid, p. 12.

[5] Ibid.

[6] Other sources of funding for uncompensated care and shortfalls include income from charitable trusts, grants, contributions, and draw-downs from funded depreciation.

[7] AHA-HAS Monitrend Data: "Six Month Medians for the Period ending June 30, 1986." American Hospital Association, Chicago, IL.

The disproportionate share hospital may also have higher care costs. Ill health and delays in seeking care are associated with poverty and lack of adequate health insurance.[8] These factors may result in the disproportionate share hospital having to treat sicker patients with a larger number of health problems.

During the 1980s, there had been a rise in the number of uninsured and underinsured people and, simultaneously, the development of price competition. These two factors have compounded each other. The growing uninsured and underinsured population increases demand for uncompensated care. Payors' demands for discounts and risk assumption by hospitals have reduced the ability of hospitals to shift the burden of uncompensated costs onto insured patients. Price competition threatens serious penalties - such as loss of adequately financed patients, operating losses and, ultimately, diminished ability to provide care - on those hospitals which are forced to cost-shift increasing uncompensated care burdens.[9]

When children's hospitals are disproportionate share hospitals they are doubly disadvantaged in the competitive market. As tertiary, pediatric-only, teaching hospitals, children's hospitals incur higher costs than the average hospital and may be in a less-than-price-competitive position for primary inpatient and outpatient services for reasons other than efficiency.

Children's hospital attract, and must staff for, a more costly mix of patients than other hospitals.[10] They maintain a wide array of specialized equipment and supplies and provide services, such as play therapy, found in few other hospitals. The heavy teaching intensity, while enhancing treatment capability and producing the next generation of pediatric physicians, also generates additional costs for the current generation of patients and payors. Finally, children's hospitals often compete with general hospitals which are able to cross-subsidize pediatric care (from adult patient revenue) and thus underprice it.

From the perspective of Medicaid public policy there is good reason to be concerned about the situation of disproportionate share providers. Disproportionate share providers are essential in providing access to care for Medicaid patients and unresourced patients. The U.S. House of Representatives report accompanying legislation to mandate Medicaid disproportionate share payments explained the issue:

> "Precisely because States were given flexibility in establishing payment rates, it is necessary to assure that those payment rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as

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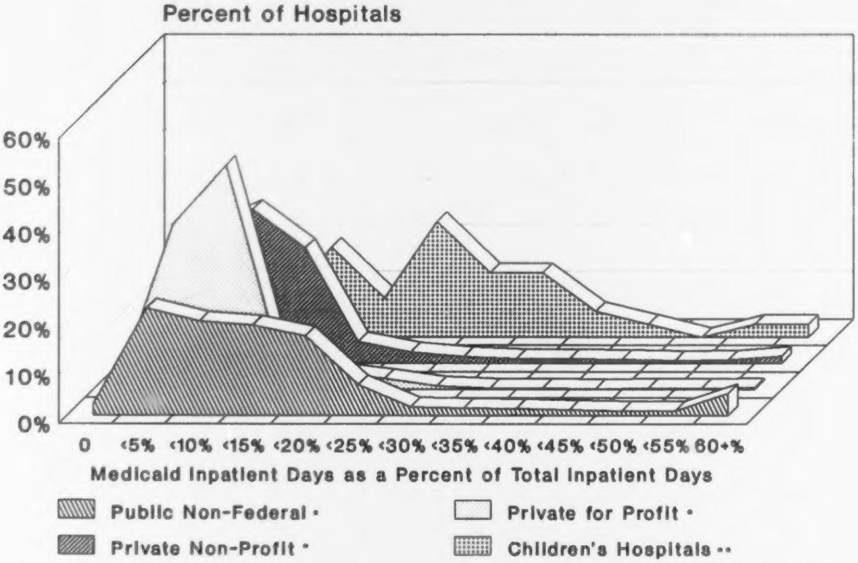
[8] "Access to Health Care in the United States: Results of a 1986 Survey," The Robert Wood Johnson Foundation, Special Report Number Two, Princeton, New Jersey, 1987.

[9] "Setting the Record Straight: the Provision of Uncompensated Care by Not-for-Profit Hospitals," Lawrence S. Lewin, Timothy J. Eckels, and Linda B. Miller, The New England Journal of Medicine, Vol 318, No. 18 (May 5, 1988), p.1212.

[10] Almost thirty percent of children's hospitals' beds are devoted to special care units, as compared to 9.4 percent of beds in community hospitals. Source: "Highlights of Children's Hospital, Patients, Services and Finances," p. 11.

Exhibit V - 1

Medicaid Share of Total Inpatient Days



Sources: •Congressional Research Service Analysis of 1984 AHA Annual Survey Data.
•• NACHRI Medicaid Reimbursement Survey, 1988 (1987 data for 37 acute care Children's Hospitals).

> financially undesirable. These 'disproportionate share' hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace."[11]

The sections which follow illustrate the important role children's hospitals play in serving Medicaid children and how, as disproportionate share providers, children's hospitals are particularly vulnerable to Medicaid policies.

C. Inpatient Utilization

Medicaid patients use a disproportionate share of children's hospitals' inpatient services. In the average acute care children's hospital, Medicaid patients account for 25.6 percent of the admissions and 28.9 percent of the inpatient days.

Few general hospitals devote as large a portion of their inpatient days to Medicaid patients as do children's hospitals (see Exhibit V-1). Only 11 percent of public general hospitals and 5.6 percent of non-profit general hospitals provide 30 percent or more of their total inpatient days to Medicaid patients. In contrast, 40.5 percent of acute care children's hospitals have Medicaid inpatient loads of 30 percent or more. Almost three-quarters of children's hospitals (73.0%) exceed 20 percent Medicaid days, compared to only one in five public general hospitals (19.3%) and one in ten non-profit general hospitals (9.4%).[12]

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[11] "Report of the House of Representatives Accompanying H.R. 3545," U.S. House of Representatives, Washington, DC, November 1988, p. 524.

D. Inpatient Case Mix Profile of Medicaid Children

Medicaid children who are inpatients of children's hospitals and general hospitals differ in several regards from other hospitalized children. In particular, compared to non-Medicaid children, the Medicaid inpatients are:

- Are younger in age;
- Are hospitalized for different illnesses;
- Stay longer on average for a given diagnosis;
- Have a higher proportion with exceptionally long lengths of stay for a given diagnosis (i.e., more long stay "outliers") indicative of greater severity of illness;
- Are more likely to have a catastrophic illness (i.e., incur charges of $50,000 or more per discharge).

Medicaid children with certain conditions tend to be concentrated in certain types of hospitals. That is, a very high proportion of children with congenital, chronic, or other conditions which require specialized care receive their care at children's hospitals or general teaching hospitals. In this regard, the provision of hospital care to Medicaid children is similar to that for non-Medicaid children in that the more specialized care is highly regionalized.

The inpatient case mix profile of Medicaid children was compared to that of non-Medicaid children using a 1986 medical record abstract data base built by NACHRI and the Commission on Professional and Hospital Activities. The data base included 225,030 cases from 35 children's hospitals, 113,365 pediatric cases from 45 teaching general hospitals, and 91,884 pediatric cases from 150 non-teaching general hospitals. Each case was grouped by Pediatric Modified Diagnosis Related Groups (PM-DRGs) and analyzed from a number of different perspectives. To maintain consistency across hospitals, all maternity cases (MDC 14) and normal newborns were excluded from the database, as these patients are rarely seen in children's hospitals. The comparisons presented below are based on comparing children whose primary expected payor at admission was Medicaid with all other children in these institutions.

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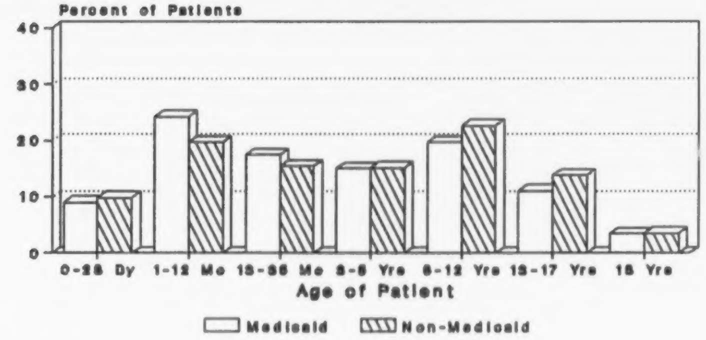
[12] Although the average public hospital sees a smaller proportion of Medicaid patients than children's hospitals, many have much larger uncompensated care and Medicaid loads. Uncompensated care and other uninsured patients accounted for 38 percent of gross revenue in 1987. In the average member of the National Association of Public Hospitals, which are predominately large, inner-city hospitals, Medicaid patients accounted for 37 percent of inpatient days in these hospitals. Source: National Association of Public Hospitals, unpublished survey data.

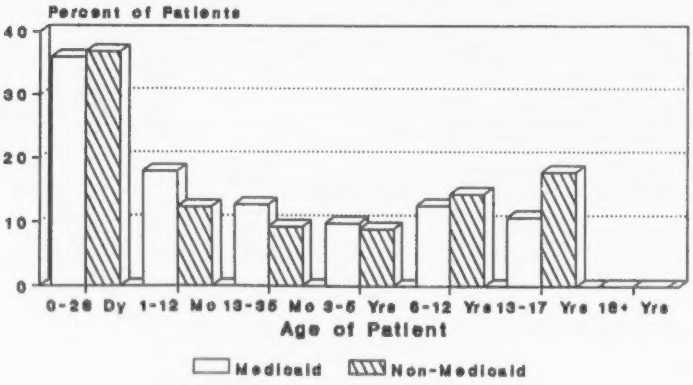
Exhibit V - 2

Age Distribution of Pediatric Inpatients by Medicaid Status and Hospital Type, 1986

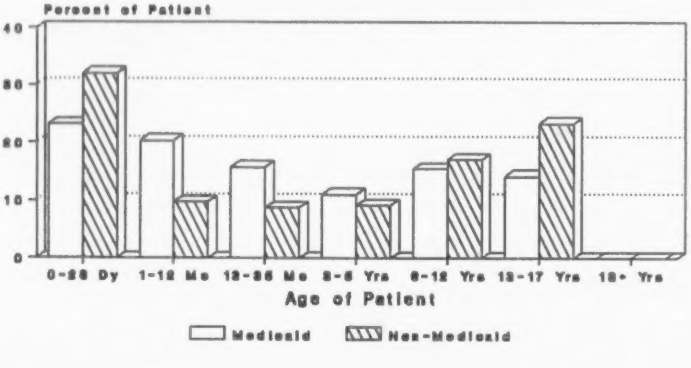
Children's Hospitals



Teaching General Hospital Pediatrics



Non-Teaching Hospital Pediatrics



Source: NACHRI Case Mix Data System.

1. Age

Medicaid children are younger than non-Medicaid children in all 3 hospital settings, as shown in Exhibit V - 2. In children's hospitals, for example, the median age of Medicaid children was 3 years, whereas the median age of non-Medicaid children was nearly 4 years.

In large part this difference is attributable to Medicaid eligibility rules. A large proportion of Medicaid children have historically attained their eligibility through the Aid to Families with Dependent Children (AFDC) program. This program covers more children of the younger ages than the older ages.

2. Illnesses

The conditions chiefly responsible for causing a hospital admission (i.e., principal diagnosis) tend to be quite different for Medicaid children and non-Medicaid children.

Across all three hospital settings, a higher proportion of Medicaid patients were admitted for conditions which are grouped into the PM-DRG major diagnostic categories for respiratory illnesses, infections and parasitic illnesses, blood disorders, burns, HIV infection, trauma and drug effects, and mental illness (see Exhibit V - 3).

There are relatively fewer Medicaid patients admitted for circulatory, musculoskeletal, myeloproliferative (e.g., leukemia), and male reproductive disorders. There are approximately the same proportion of Medicaid patients admitted for neurologic, eye, ear/nose/throat, digestive, hepatobiliary, skin, endocrine/metabolic, kidney, and female reproductive disorders.

In sum, the inpatient profile of Medicaid children is different from that of non-Medicaid children in two respects. They have a higher prevalence of chronic child health conditions (e.g., respiratory illnesses and blood disorders) and a higher prevalence of conditions associated with environmental, social and economic circumstances (eg., trauma and drug effects, burn, mental illness and HIV infection). This profile suggests that Medicaid children will need a great deal of care and attention to help achieve favorable health outcomes.

3. Length of Stay and Outlier Rates

The average length of stay for Medicaid children is considerably higher than for non-Medicaid children. This finding is consistent across hospital settings, as shown in Exhibit V - 4.

The average length of stay for Medicaid children varied from 14 percent to 24 percent longer than for non-Medicaid children across the three hospital groups. Approximately half of this differential is attributable to the fact that there was a higher proportion of Medicaid children with exceptionally long stays for the given diagnosis (i.e., outlier patients).[13] These outlier patients are considered to be clinically atypical (eg., more severely ill) compared to patients in the same diagnostic group who have normative stays. The other half of the differential is attributable to longer lengths of stay for patients whose lengths of stay were within a range considered normal variation typical of the diagnosis (i.e., inlier patients).

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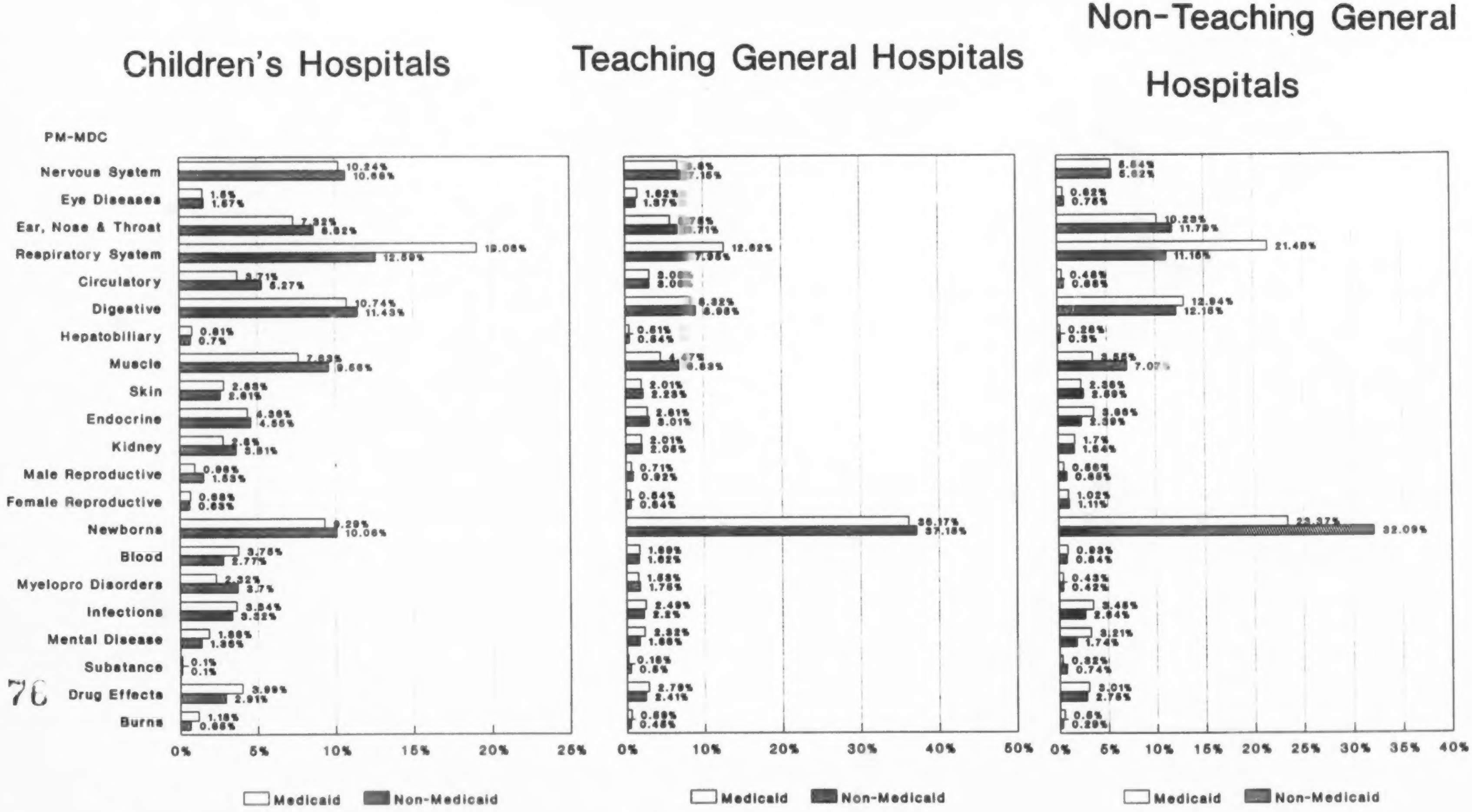
[13] Outlier length of stay thresholds for each PM-DRG were set at the geometric mean length of stay plus the lesser of two standard deviations or 18 days.

Exhibit V - 3

Diagnostic Distribution of Pediatric Discharges by Medicaid Status and Hospital Type - 1986



Source: NACHRI Case Mix Data System.

Exhibit V - 4

Length of Stay for Medicaid and Non-Medicaid Pediatric Inpatients by Type of Hospital and Outlier Status - 1986

	Type of Hospital					
	Children's Hospital		Teaching Hospital Pediatrics		Non-Teaching Hospital Pediatrics	
	Medicaid	Other	Medicaid	Other	Medicaid	Other
Average Length of Stay						
All Cases	7.4	6.5	8.4	6.8	4.7	3.9
Inliers	4.7	4.5	5.2	4.6	3.7	3.3
Outliers	41.2	40.0	48.4	33.6	32.3	29.6
Percent of Cases						
Inliers	92.7%	94.3%	92.7%	94.57%	96.5%	97.5%
Outliers	7.3	5.7	7.3	5.4	3.5	2.5
Percent of Days						
Inliers	58.8%	65.0%	57.8%	66.4%	75.6%	81.3%
Outliers	44.2	35.0	42.3	33.6	24.4	18.7

Source: NACHRI Case Mix Data System

In the instance of children's hospitals, 7.3 percent of discharges and 41.4 percent of total days (22.6 percent beyond outlier threshold) are associated with Medicaid outlier patients. This contrasts with 5.7 percent of discharges and 35.0 percent of total days (17.6 percent beyond outlier threshold) for non-Medicaid children. In addition to illustrating that Medicaid inpatients are more severely ill than other hospitalized children, these findings also portray the vulnerability of children's hospitals to payment systems which penalize outlier patients or set rates based on the normative patients. Over one-third of the days of care provided by children's hospitals were used by exceptionally sick and long staying patients.

In sum, the longer lengths of stay and the higher outlier rates for Medicaid children suggest that Medicaid hospitalized children are an especially sick group of children. This pattern underscores the importance of Medicaid payment methodologies and rates for children's care.

4. Catastrophic Illness

As with the higher average lengths of stay and outlier rates, Medicaid children have a higher rate of catastrophic illness, defined as a hospital stay with charges of $50,000 or greater. This holds true across all three hospital groups, as shown in Exhibit V - 5.

In the instance of children's hospitals in 1986, 1.8 percent of discharges, 21.2 percent of days, and 27.4 percent of charges were associated with Medicaid patients whose charges were greater than $50,000. This compares to 1.6 percent of discharges, 18.0 percent of days, and 24.1 percent of charges for non-Medicaid patients in children's hospitals. There are not as many catastrophic pediatric patients in teaching general hospitals and non-teaching general hospitals, but the Medicaid/non-Medicaid patterns are very much in the same direction.

In sum, this information indicates that Medicaid children are especially vulnerable to catastrophic illness and that children's hospitals play an especially important role in serving catastrophically ill Medicaid children. This makes it particularly important that Medicaid programs provide adequate payment for children with exceptionally long or costly hospitalizations.

5. Regionalization of Specialized Pediatric Care

The provision of care to children with congenital anomalies (e.g., cardiac or neurologic malformations), chronic conditions (eg, sickle cell anemia, cystic fibrosis), and other conditions (eg, low birth weight, cancer) who require specialized care is highly regionalized. The majority of the inpatient care for these conditions is provided at children's hospitals and other teaching hospitals. The same holds true for much of the outpatient care which is provided in specialty clinics (eg., clinics for cerebral palsy, spina bifida, hemophilia, etc).

To illustrate, the percentage of total Medicaid pediatric discharges in PM-DRGs for cardiac, blood disorder, and myeloproliferative (eg, leukemia) disorders ranges from 9.8 percent at children's hospitals, to 6.3 percent at teaching general hospitals, to 1.8 percent at non-teaching general hospitals. The percentages for non-Medicaid children range from 11.8 percent to 6.5 percent to 1.9 percent, respectively.

In sum, specialized health care for children, both Medicaid and non-Medicaid, is highly regionalized. The high level of regionalization allows for economies of scale and expertise in treating conditions which are relatively uncommon. However, given the smaller size of the pediatric population compared to the adult inpatient population, the economies of scale in pediatric regionalization would likely be at a lower level. This is an important consideration to include in the development of alternative financing or delivery systems for a children's population group. In other words, access to care for certain conditions is highly dependent on participation of children's hospitals and teaching general hospitals.

E. Outpatient Utilization

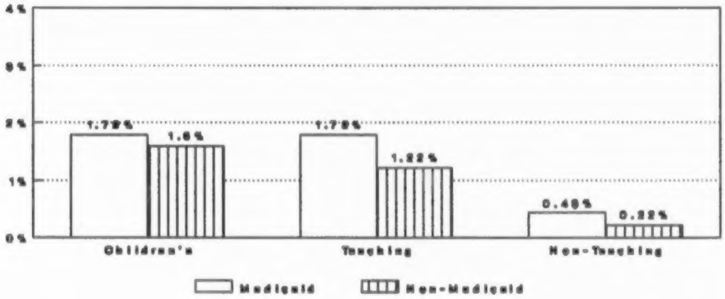
Children's hospitals also provide a disproportionate share of their outpatient services to Medicaid children. In the acute care children's hospitals, Medicaid accounts for 33.7 percent of emergency room visits, 31.5 percent of clinic visits, and 21.1 percent of ambulatory surgery. For specialty children's hospitals, 60 percent of outpatient visits are made by Medicaid patients.

In many acute care children's hospitals, the ER is a major source of inpatient admissions. On average, 39.3 percent of all Medicaid inpatient admissions came from the ER (based on 12 free-standing acute children's hospitals providing data), about the same proportion as for all patient admissions in these

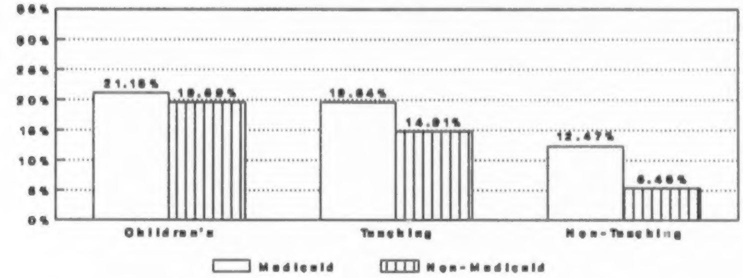
Exhibit V - 5

Catastrophic Pediatric Hospital Stays as a Percent of Cases, Days, and Charges by Medicaid Status and Type of Hospital - 1986

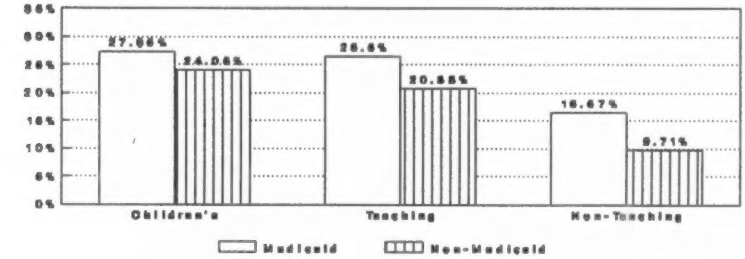
Percent of Cases
with Charges of $50,000+



Percent of Inpatient Days
for Cases with Charges of $50,000+



Percent of Total Charges
for Cases with Charges of $50,000+



Source: NACHRI Case Mix Data System.

hospitals. On average, one of ten Medicaid ER visits resulted in a direct admission, again about the same rate as for all patients.

Although the NACHRI survey did not address the extent to which the ER is used as a regular source of primary care by Medicaid and low income patients, anecdotal information strongly suggests that this is the case, particularly in those children's hospitals in inner city locations. Philosophically, children's hospitals would prefer to serve these primary care patients in a more appropriate setting. However, as a practical matter, sick children in need of care are not turned away. One children's hospital operates a 24 hour urgent walk-in clinic for its non-emergency patients. Others place first priority on emergency care, which may mean extended waiting for non-emergency patients. The fact that families in the vicinity of children's hospitals continue to rely on ERs for basic care reflects a shortage of primary care practitioners in these areas available to serve Medicaid and low income patients, as well as the trust the patients' families place in the high quality of the care provided by the children's hospitals.

As major pediatric teaching institutions, most acute care children's hospitals provide both primary care outpatient clinics and a wide range of specialty care clinics. It is not unusual for a larger children's hospital to operate 30 or more specialty clinics. Children's hospitals generally believe it is in the best interests of children to receive outpatient care in lieu of inpatient care whenever medically appropriate. As a result, 48 percent of all surgical operations in children's hospitals were performed on an outpatient basis in 1986.[14] Many children's hospitals are also providing extremely sophisticated diagnostic and treatment services on an outpatient basis.

F. Charity and Bad Debt

Children's hospitals provide a disproportionate share uncompensated care to the poor and inadequately insured. The average acute care children's hospital (N=46) devoted 8.3 percent of its gross revenue to charity and bad debt and one-third of these hospitals exceeded 10 percent. By contrast, charity and bad debt accounted for 6.4 percent of gross revenue in the average general hospital in 1987.[15] For the specialty care children's hospitals (N=6), charity and bad debt averaged 4.75 percent of gross revenue.

Allocating a larger share of hospital services to charity and bad debt patients places a hospital in a competitive disadvantage relative to other hospitals, as does having a disproportionate share of undercompensated Medicaid patients. This can make it difficult for these disproportionate share hospitals to respond to HMO and other payor pressures for discounts. If the disproportionate share hospitals' competitive disadvantage results in a loss of adequately financed patients, then their capacity to maintain the same level of commitment to the Medicaid and inadequately financed patients is undermined and access to care for the poor is diminished.

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[14] "Highlights of Children's Hospitals Patients, Services, and Finances," p. 15.

[15] American Hospital Association, unpublished data from the 1987 AHA Survey.

Chapter VI

The Impact of Medicaid Payment Shortfalls and Medicaid Uncompensated Care on Children's Hospitals and Their Ability to Serve Children

Introduction

This chapter examines the adequacy of Medicaid payment in meeting the costs of delivering care to Medicaid-eligible children in children's hospitals. The 1987 financial data reported by 32 freestanding acute children's hospitals and 4 specialty care children's hospitals reveal an unmistakable pattern of inadequate Medicaid payment. In the average acute care children's hospital:

- Medicaid paid only 74 to 75 cents for every dollar of cost the hospital incurred in providing care for Medicaid children. These Medicaid losses equaled 7 to 8 percent of the cost of all the care provided by the average children's hospital.

- Three factors account for the children's hospitals' losses of 25 - 26 cents per dollar of cost incurred serving Medicaid children (as shown in Exhibit VI-1):

  - Payment level shortfalls due to inadequate reimbursement rates paid for Medicaid-covered services produced an average loss of 15.8 cents per dollar of cost incurred by the children's hospitals in treating Medicaid children.

  - Medicaid uncovered services due to limits on the amount of covered care (eg., covering only 12 days per hospital stay or only 4 outpatient visits per month) and excluded services (eg., not covering outpatient physical therapy) accounted for an average loss of 6.2 cents per dollar of cost for the care provided to these children.

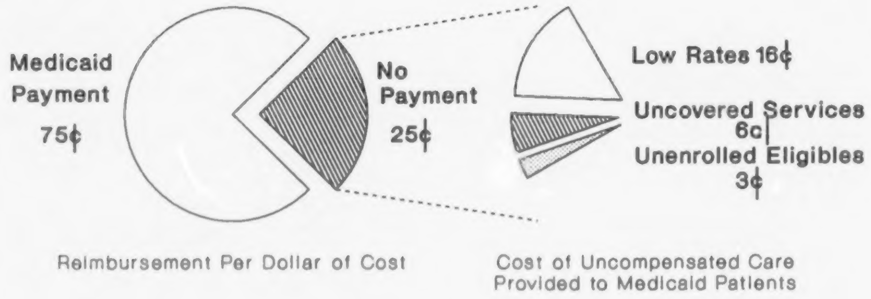
  - Services provided to children who were eligible for Medicaid, but who did not enroll in Medicaid amounted to additional losses equaling three to four cents per dollar of cost. Because children's hospitals found it difficult to account for the losses due to enrollment problems, this loss and the total Medicaid loss are probably under-estimated.

The inadequacy of payment for Medicaid patients is doubly serious: not only are the Medicaid losses large as a percent of cost, but they are also large and difficult to manage in terms of total dollars. This is because the children's hospitals are disproportionate share providers: they serve large numbers of Medicaid patients, as well as poor and inadequately insured children, not covered by Medicaid, who are unable to pay. More than one-third of the average acute care children's hospital's services are provided to Medicaid, charity, and bad debt patients.

One previously unrecognized impact of Medicaid payment inadequacies is evident in the survey data: a major portion of the children's hospitals' charity and bad debt are actually being used to support Medicaid-enrolled children because of services which Medicaid programs choose to restrict or not cover at all. Continued access to services for these and other children is a growing concern because the financial impact of Medicaid on the children's hospitals is diverting resources which could otherwise be used for unsponsored care.

Exhibit VI - 1

COMPONENTS OF MEDICAID LOSSES
Per Dollar of Cost for Care of Medicaid Patients



Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

A. Definition of Payment Adequacy

This report uses "patient care cost," as defined in Medicare principles, as the basis for measuring Medicaid payment shortfalls to children's hospitals. This basis of measurement is used solely because it is fairly well defined and because most hospitals' cost accounting systems have been set up to provide for the generally accepted accounting principles embodied in this definition. However, there is no intention of implying that reimbursement at "cost" represents adequate payment. It is used merely as a minimum workable standard, below which payment is clearly inadequate.

There is considerable debate about what constitutes adequate payment to hospitals and how to measure it. The issue of what is included in "cost" and whether it represents adequate compensation is a complex and technical matter. The Medicaid law offers one view: it requires payments to "meet the costs of efficiently and economically operated hospitals meeting quality of care requirements." However, absent definitions of efficiency and economy, this standard of adequacy is hollow -- an observation which may partially explain why HCFA has done virtually nothing to enforce this provision of the law.[1]

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[1] HCFA requires states to provide a written assurance that their Medicaid payment rates meet this standard. However, HCFA does not routinely require states to submit any evidence to support the assertion, nor does HCFA include any assessment in its Medicaid performance reviews. HCFA may occasionally delay approval of a state plan and request additional information from the state when it is obvious that rates have been subject to a very large cut in response to a budget crisis.

What the reader should understand is that hospitals, like all businesses, have financial requirements which include more than cost as defined by Medicare. For example, the definition of cost includes recovery of only the original cost of equipment and buildings, not the replacement cost. Hospitals need revenues in excess of cost merely to replace worn-out equipment with exactly the same new equipment because of inflation. The same is true for working funds used to pay employees and suppliers. As wages and prices rise, hospitals must have additional working capital on hand. In other words, hospitals need to earn a positive margin just to keep on doing what they have been doing.

Hospitals also need to generate new funds for new programs and new types of equipment. Medical technology is constantly advancing and the public expects hospitals to at least keep up, if not lead in the provision of modern medicine. Hospitals also need funds to start new programs, to meet added demand as the U.S. population continues to grow, and to buy new technology which is more effective in making patients healthy. Since payment at cost does not meet the hospitals' financial requirements for capital, hospitals must often borrow, thus raising the costs of care to the patients and payors. Those hospitals with a disproportionate share of uncompensated care patients may have difficulty accessing capital, with unfortunate consequences for the quality of care and appearance of these institutions.

Another component of hospitals' financial requirements which is not embodied in the Medicare cost definition is uncompensated care.[2] This is particularly important in disproportionate share hospitals. When a payor pays only the direct cost of its patients, it shifts the burden of uncompensated care to other payors. If all payors insisted on paying only cost, then financing care for the medically indigent would become an almost intractable problem.

Thus, when this study addresses Medicaid payment adequacy relative to cost, it should be understood that the starting base of revenue is inadequate to support hospitals' financial requirements, particularly those generated from commitments to serving persons without adequate health care financing.

A secondary issue in payment adequacy is how the payment methodology sets incentives and disincentives. A payment system may provide adequate revenue to the hospital in aggregate, but at the same time make it less attractive for the hospital to treat certain kinds of patients or to provide a less expensive modality of treatment. For example, very inadequate outpatient rates could give a hospital an disincentive to perform outpatient surgery, even though this would cost the payor less than inpatient surgery. Inadequate payments for certain types of patient can also result in serious access problems. A dramatic example of such access problems because of inappropriate payment methods and limits occurred recently for two Medicaid children in Texas needing liver transplants.[3] The children were unable to obtain the life-saving procedure until a judge overturned the Texas hospital coverage limit of $50,000 per year.

The analysis presented below addresses the adequacy of aggregate Medicaid payments to children's hospitals. It identifies the relative contributions to aggregate Medicaid payment shortfalls arising from limits on services and benefits, from problems eligibles have in enrolling in Medicaid, and from inadequate payment rates. However, the analysis is not designed to draw inferences as to the appropriateness of the payment methods.

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[2] Medicare's definition of cost includes bad debt costs, but only those resulting from Medicare patients' failure to pay for copayments and deductibles on Medicare covered services.

[3] Veilia Montoya v. Marlin W. Johnston, U.S. District Court, Western District of Texas, 654 F.Supp. 511, Feb. 23, 1987.

B. Medicaid Payment Adequacy in General

Children's hospitals are not alone in their concern for the adequacy of Medicaid payments. For example, an analysis of cost reports for Georgia hospitals revealed that total Georgia Medicaid payments fell short of costs by 11.7 percent and 13.8 percent in 1986 and 1987, respectively.[4] Other hospital associations and organizations have documented Medicaid payment shortfalls. Although there is widespread concern about Medicaid shortfalls, it is important to recognize that the dollar impact of these percentage losses is most severe for those hospitals with large Medicaid populations.

It is widely accepted, particularly among hospitals and physicians, that Medicaid payment rates are based more on what the state decides to pay (often because of state Medicaid budget constraints) than on the financial requirements or costs of the providers, either individually or collectively. The public record also documents occasions when public officials justify reimbursement cut-backs solely in terms of what the state can afford to spend.[5]

From the public's perspective, the issue may be less whether the level of Medicaid payments is adequate or fair, and more whether the combined total dollar burden of Medicaid shortfalls and other uncompensated care affects hospitals' capacity to maintain their current levels of service and access to care. In this regard, the situation of children's hospitals serves as a laboratory for assessing how well or poorly Medicaid serves the interests of children because their high loads of Medicaid and unsponsored patients, together with service devoted almost exclusively to children, magnify the effects of these factors.

C. Components of Medicaid Payment Problems

The issue of Medicaid payment adequacy is composed of three major components:

- Payment level shortfalls -- partial compensation for Medicaid covered services delivered to individuals actually enrolled in Medicaid -- resulting from low rates of reimbursement;
- Medicaid uncovered care -- total lack of compensation for care provided to persons enrolled in Medicaid -- because of limitations and restrictions on what services Medicaid covers; and
- Unenrolled eligibles -- uncompensated care delivered to persons who were eligible for Medicaid but not enrolled -- resulting from enrollment barriers and the unavailability of Medicaid IDs.[6]

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[4] "An Analysis of Payments to Hospitals Under the Georgia Medicaid Program," for the Georgia Hospital Association by Health Care Investment Analysts, Inc., Baltimore, Maryland, August 1, 1988.

[5] This was the basis of Colorado Medicaid's defense in a challenge to payment cuts of 40 percent. Even though the cuts resulted in rates that did not meet the costs of a single hospital in the state, the District Court judge ruled in favor of the state because the state had already established the precedent of setting payment rates by dividing the amount of funds which had been appropriated by the expected number of inpatient days. The U.S. Court of Appeals overturned the District Court and ruled the cut in rates is a violation of Federal law. Amisub v. Colorado DDS and Ibarra, U.S. Court of Appeals 10th Circuit, No. 88 - 2482 and U.S. District Court, No. 88-F-1024.

[6] In one state which allows hospitals to query the enrollment information system to obtain IDs, it takes at least one month for the ID to be assigned and made available to hospitals after eligibility is officially established. Until the ID is available, the hospital cannot bill for services rendered. In other

It is important to view Medicaid payment in terms of these three components for several reasons. Each component is responsive to a very different set of policies. The implications for children's access to care differ considerably among the components. Finally, differences in the way hospitals track and report Medicaid, charity, and bad debt in their financial systems tend to obscure the inadequacies of Medicaid as a financing program for poor children.

Accurately tracking the resource consumption and financing for Medicaid patients is a complex and difficult task for a variety of reasons, including retroactive eligibility determinations, dual coverage, inadequate feedback from Medicaid fiscal agents regarding why claims are not paid or only partially paid, and the design of hospital accounting and receivables systems. Some hospitals include in Medicaid gross revenue only those charges for the services which Medicaid actually covered. Others include both covered and uncovered services delivered to actual eligibles. Some use assignment at admission of Medicaid as the expected major or primary payor to define Medicaid gross revenue, thus including potential and actual Medicaid enrollees as well as covered and uncovered services. These differences in hospital information practices tend to under-report the full impact of Medicaid and may lead to incorrect conclusions about where the payment problems lie.

The NACHRI survey asked children's hospitals to assess their data practices and then, based on this examination, to identify and reallocate the gross revenues for Medicaid enrollees and eligibles into the three categories given above. Of the 36 responding hospitals which provided adequate and acceptable financial data, 22 were able to estimate or account for Medicaid uncovered charges, but only nine were able to separately estimate the charges for the Medicaid unenrolled group.[7]

As a result, the study data provided a reasonable, but conservative estimate of the costs of uncovered care delivered to Medicaid enrollees. However, since only nine hospitals specifically reported the volume of care provided children who were eligible for Medicaid but who did not enroll in Medicaid (or did not supply a valid Medicaid ID card), the total losses due to uncovered, uncompensated care provided to Medicaid patients (including the unenrolled) was under-reported by approximately three to four percent. Thus, the data analysis presented below references total shortfalls excluding the unenrolled Medicaid eligibles.

In the presentation below, uncovered, uncompensated care provided to the combined group of unenrolled and enrolled Medicaid eligibles is referred to as Medicaid-related charity and bad debt.

The data are for hospital fiscal years ending in calendar 1987. The analyses below relate only to the 36 hospitals providing detailed financial data. As a result, averages for this group presented in this chapter may vary slightly from those reported elsewhere in this report for the larger group of hospitals responding to the survey.

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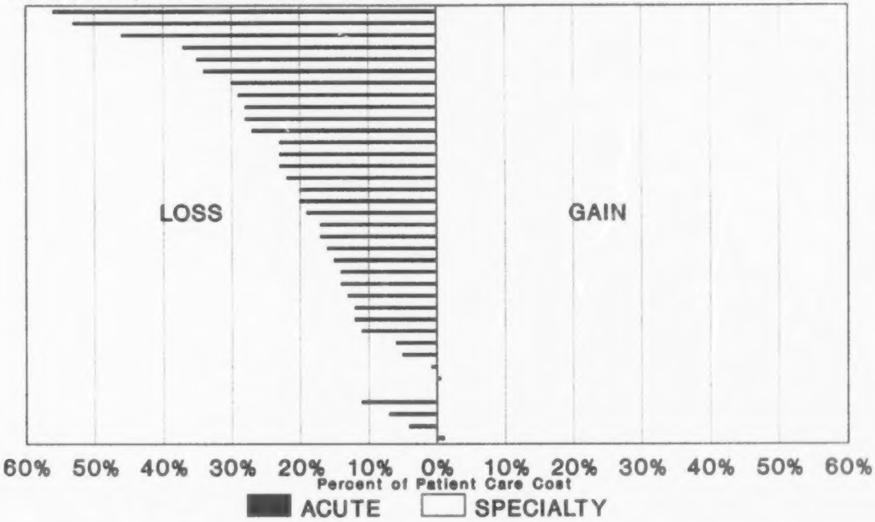
states, the hospital must constantly re-contact Medicaid applicants whose enrollment is pending verification.

[7] The 14 who did not estimate the amount of uncovered care provided to Medicaid-enrolled children indicated that these charges were included in total charity and bad debt, but the hospitals did not have sufficient information to re-allocate a portion of charity and bad debt to this category. There were also three hospitals which indicated that they included all Medicaid charges, both covered and uncovered, in the covered charges category. Since these hospitals were all located in states with few or no restrictions on covered services, and since the results for these hospitals had a very small impact on the overall averages, the estimate of payment shortfall is probably reasonably accurate for these hospitals.

Exhibit VI - 2

MEDICAID SHORTFALLS ON TOTAL SERVICES TO MEDICAID ENROLLEES
as % of Patient Care Expense



Note: Excludes losses on Medicaid eligible but unenrolled patients.
Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

1. Total Medicaid Shortfall (excluding Medicaid unenrolled)

The total Medicaid shortfall (excluding unenrolled Medicaid eligibles) was measured as the difference between the patient care costs incurred by children's hospitals in serving Medicaid enrolled children and the payments received from Medicaid.[8] These losses reflect payment shortfalls on covered services plus losses on care of Medicaid enrollees which was uncompensated because of service coverage limits and exclusions. They do not include losses from patients who were eligible for Medicaid but who either never successfully completed the enrollment process or who did complete the process but did not provide a Medicaid ID number to the hospital.

The results indicate a consistent pattern of Medicaid payment inadequacy:

o Thirty-four of the 36 children's hospitals (94.4%) were paid less than cost (see Exhibit VI-2).[9]

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[8] Any services paid for by other third-parties or the patients were excluded from both costs and revenues.

[9] Of the 32 acute care hospitals, 31 did not recover cost; of the four specialty children's hospitals, three did not recover cost.

- The average acute care children's hospital had Medicaid losses equal to 22 percent of the cost of care for Medicaid enrollees (i.e., payment covered only 78 percent of cost, not including the costs for the unenrolled eligibles).

- Almost half (46.9%) of the acute care children's hospitals had losses exceeding 20 percent of cost.

- More than 20 percent (21.9%) of acute care children's hospital had losses exceeding 30 percent of cost.

- The average acute care children's hospital's total dollar loss on total services (covered and uncovered) to Medicaid enrollees was $3.2 million; two children's hospitals had total Medicaid losses exceeding $9 million.

- Percentage losses in acute care children's hospitals were larger on average for outpatient care to Medicaid enrollees than for inpatient care: 27.3 percent versus 20.8 percent; three times as many children's hospitals had outpatient losses in excess of 40 percent of cost than had inpatient losses exceeding 40 percent of cost.[10] The higher percentage losses on outpatient care reflects a combination of both low payment rates and uncovered services.

- Payment shortfalls were smaller for the four specialty children's hospitals: the average loss was 5.1 percent and the largest loss was 10.7 percent. However, because Medicaid patients consume such a large portion of the care in these hospitals (over 50%), these translate into large dollar losses which may be hard to balance with the revenues from the smaller portion of other paying patients.

It should be reiterated that these estimates of losses are on the low side because slightly over one-third of the hospitals were not able to provide an estimate of the amount of uncovered services delivered to Medicaid enrollees. If it were assumed that their losses on uncovered care parallel those of the other hospitals, the total loss on Medicaid-enrolled patients would increase another two percentage points. Furthermore, the losses do not include the 3 - 4 percent loss due to totally uncompensated care given to the unenrolled Medicaid-eligible children. Thus, the average total loss on Medicaid patients may be closer to 28 percent.

The contrast between the impact of Medicaid on children's hospitals and the impact of Medicare on general hospitals is striking. Medicaid is the dominant government payor for children's hospitals, while Medicare is the dominant government payor in general hospitals. Yet, their impacts are very different. In fiscal year 1987, the aggregate Medicare prospective payment system operating margin for general hospitals was a positive 5.2 percent.[11] For disproportionate share hospitals in large urban areas (greater than 1 million population) and other urban areas, the Medicare margins were 9.9 percent and 9.1 percent, respectively. These positive Medicare margins contrast strongly with the large negative Medicaid margin (on enrolled eligibles only) of 22 percent for the average children's hospital.

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[10] Based on the 28 of the 32 hospitals which reported both Medicaid net revenue and Medicaid patient charges separately for inpatient and outpatient care.

[11] Although PPS margins were positive for the early years of PPS, they have been projected to drop to the break-even point or lower. It should be noted that the PPS operating margins are computed on a somewhat different basis as they do not reflect Medicare costs or revenues for capital, graduate medical education, or organ acquisition. Source: PPS Year 4 operating margin as reported in "Medicare Prospective Payment and the American Health Care System: Report to the Congress," Prospective Payment Assessment Commission, Washington, DC, June 1989, p. 132.

2. Relationship of Total Medicaid Shortfalls (excluding losses on unenrolled eligibles) to Total Hospital Financial Results

The impact that Medicaid has on the financing of patient care in hospitals is a function of both the size of the losses and proportion of hospital resources devoted to the Medicaid patients. Other factors which affect the hospital's ability to absorb losses from Medicaid include the degree to which the hospital's other third-party payors demand discounts, the debt/equity position of the hospital, and the ability of the hospital to generate non-patient revenues, such as charitable contributions, income from charitable trusts, and income from other sources.

The analysis below examines the overall patient care margin and hospital sources of revenue and expense. Later chapters address how these losses are reported to have affected the children's hospitals' ability to offer new services or maintain existing ones. However, the study was not designed to examine the full impact of Medicaid losses, such as how they may affect the children's hospitals ability to meet third-party payors' demands for discounts or the hospitals' assets and reserves.

Almost all of the children's hospitals included in the financial analysis could be considered disproportionate share hospitals, as they devote a substantial portion of their resources to the care of Medicaid patients and other patients with inadequate financing. In all but five of the hospitals, Medicaid patients consume over 20 percent of the hospital's services, as shown in Exhibit VI-3. All of the specialty hospitals exceed 50 percent Medicaid, as do two of the acute care hospitals. The average for the specialty hospitals is 70.0 percent. For the acute care children's hospitals, Medicaid constitutes 29.4 percent of gross revenue, on average. A comparable figure for a group of public hospitals, located predominantly in large cities is 29 percent.[12]

Because Medicaid comprises such a large share of the care provided by these children's hospitals, the Medicaid losses translate to an average loss of equal to 7 to 8 percent of the cost of all the care provided by the average children's hospital. In addition to large bottom-line losses on Medicaid, children's hospitals absorb other large uncompensated care losses. Charity and bad debt account for 8.0 percent of the output of the average acute care children's hospital, 25 percent higher than the 6.4 percent of gross revenue accounted for by charity and bad debt in all hospitals.[13] In 34 percent of the children's hospitals, charity care and bad debt exceed ten percent of total gross revenue. The specialty children's hospitals devote a smaller portion of resources to charity and bad debt -- 3.4 percent -- but they also have much larger Medicaid loads.

The combined impact of Medicaid losses and a disproportionate share of Medicaid and uncompensated care patients negatively affects the hospitals' ability to meet their financial requirements. The average acute care children's hospital reported a net patient care margin of +0.9 percent, while the specialty hospitals reported net patient care losses averaging 8.4 percent.

It is evident that Medicaid is not carrying its fair share of hospital expenses when the relative contributions of Medicaid to total expenses and total revenues are compared. Medicaid accounted for

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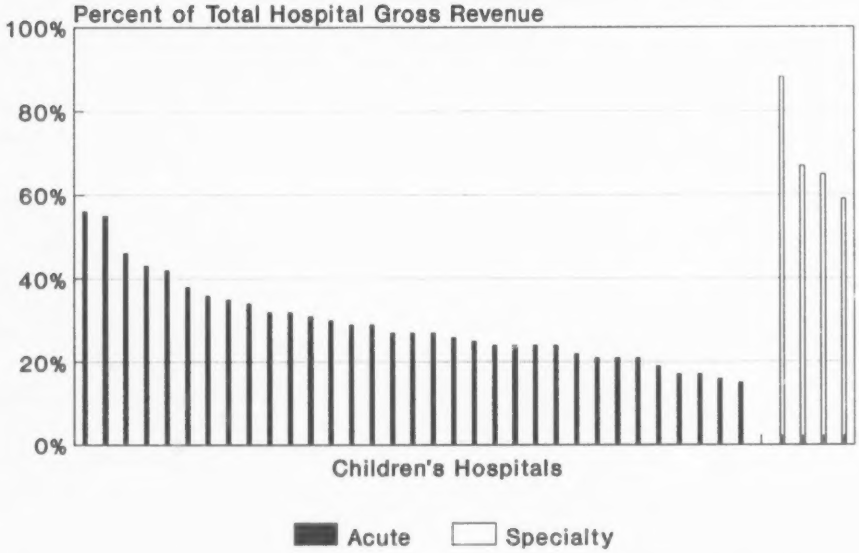
[12] National Association of Public Hospitals, unpublished data from a 1987 survey of the association membership.

[13] American Hospital Association, unpublished data from the 1987 AHA Survey.

Exhibit VI - 3

Medicaid Charges as a Percent of Total Hospital Gross Revenue



Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

32.5 percent of total hospital expenses (see Exhibit VI-4), but only 25.4 percent of net revenues. The discrepancy is largest in the acute care children's hospitals, where Medicaid accounted for 28.7 percent of total hospital expenses, but only 20.9 percent of revenues. The comparable figures for the specialty children's hospitals are 66.2 percent of expense and 61.5 percent of net revenue.

In spite of large Medicaid losses and a barely break-even average margin on patient care expense, all but three of the 36 hospitals ended their 1987 fiscal year in the black. However, this is almost entirely due to non-patient care income exceeding non-patient care expenses by an average of 5.9 percent. A major portion of the non-operating revenues would appear to be a reflection of the generous support most children's hospitals have worked to generate from their communities, plus income from earnings on contributions placed in endowment funds.[14] The continued ability of these hospitals to support uncompensated care and Medicaid losses is becoming a challenge as the marketplace for charitable contributions becomes more competitive.

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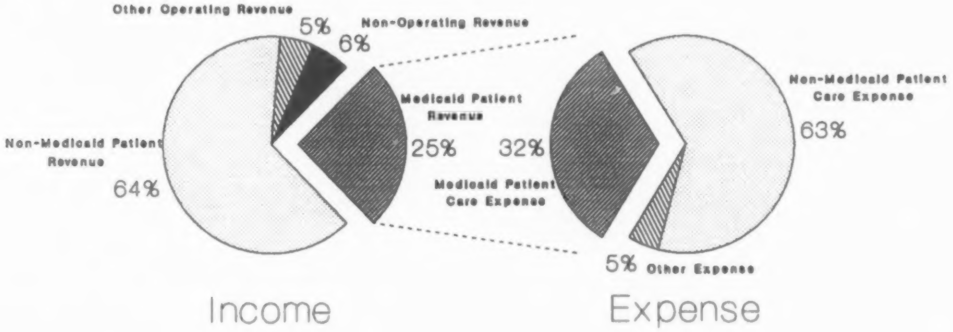
[14] Appeals for donations to support charity care in children's hospitals are no longer viewed as effective by some children's hospital development directors. Contributions are now frequently sought on the basis that contributors are building resources for the care of all children in the community. Source: Stuart Turgel, "A Development Director's Perspective," presented to the NACHRI Fiscal Officer's Forum, April 27, 1988, San Diego, California.

Exhibit VI - 4

Sources of Hospital Income and Expense



Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

Similarly, elimination or erosion of the tax exempt status of not-for-profit hospitals could have very serious implications for the ability of children's hospitals and other hospitals to continue to shoulder the burdens of inadequate Medicaid reimbursement and other uncompensated care. In effect, under-compensation from Medicaid already constitutes a very large "tax" on those hospitals with a significant commitment to serving the poor.

D. Medicaid Payment Level Shortfalls on Medicaid Covered Services

The analysis above examined the shortfall on all the services provided to Medicaid enrollees. The examination below addresses the impact of payment rates alone. In other words, it excludes the losses due to uncovered services and uncovered eligibles and looks only at payment for covered care to children enrolled in Medicaid.

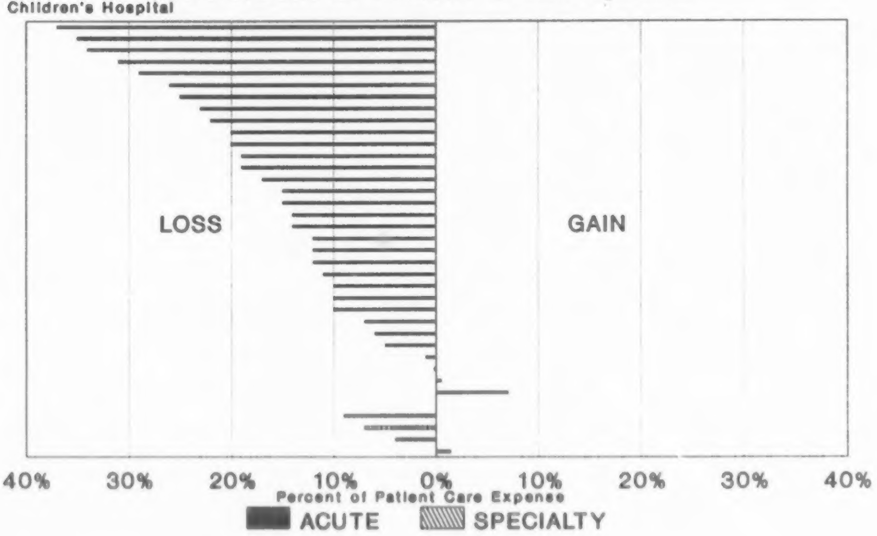
1. Medicaid Payment Level Shortfalls on Total Medicaid Covered Services

On average, the acute care children's hospitals were reimbursed only 84.2 percent of the cost of all the Medicaid covered services provided to Medicaid enrollees. The specialty care children's hospitals were paid 95.3 percent of cost. The distribution of payment shortfalls, shown in Exhibit VI-5, indicates that two acute care facilities recovered cost and two others had losses of less than one percent, while the

Exhibit VI - 5

MEDICAID PAYMENT SHORTFALLS ON MEDICAID COVERED CHARGES

As Percent of Patient Care Expense



Note: Excludes losses on Medicaid eligible but unenrolled patients.
Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

remaining 87.5 percent of acute care children's hospitals had losses of greater than five percent.[15] Losses on covered services exceeded 20 percent for 28.1 percent of the acute care hospitals.

2. Inpatient and Outpatient Payment Level Shortfalls

Twenty-eight of the 32 children's hospitals provided data on inpatient and outpatient losses sufficient to provide a general assessment of whether inpatient or outpatient payment rates are more problematic.[16]

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[15] It is instructive to note that the hospital with the positive margin of 6.6 percent receives a sizeable disproportionate share payment. This hospital is in a state with a stringent limitation on inpatient days. In spite of the positive margin on covered services, the hospital reported a loss on total services to Medicaid enrollees of 28.1 percent. The other hospital with a very slight positive margin and one almost breaking even are both in states with inpatient prospective reimbursement which allows hospitals to earn a positive margin if they become more efficient.

[16] Approximately one-third of these hospitals reported the same ratio of cost-to-charges (RCC) for inpatient and outpatient services, raising substantial doubt as to the accuracy of allocating cost to inpatient and outpatient care. Had these hospitals provided RCCs similar to those of the hospitals which differentiated inpatient and outpatient RCCs, the outpatient losses would have been larger. Thus, the direction, but not the size, of the difference may be considered accurate.

On average, outpatient reimbursement was less adequate in meeting costs than inpatient reimbursement. The average acute care children's hospitals received 86.7 percent of cost on covered inpatient care compared to 78.9 percent on outpatient services. For the three specialty hospitals which provide outpatient care, the differences were more dramatic: 97.4 percent of cost on inpatient care versus 69.1 percent for outpatient care. About 60 percent of all the children's hospital had larger percentage losses on outpatient care. However, the dollar losses on outpatient care were smaller because outpatient care accounts for a smaller portion of the hospitals' total charges.

E. Medicaid-related Charity and Bad Debt

Children's hospitals absorb losses due to the volume of charity and bad debt on the uncovered services provided to the children enrolled in Medicaid, as well as those who are eligible but not enrolled. This section examines these two components of unreimbursed care associated with service to the Medicaid population and relates the volume of these uncovered services to the children's hospitals' total provision of uncompensated care to indigent patients (i.e., total hospital charity and bad debt).

The ability to measure the total Medicaid-related charity and bad debt and its two components is somewhat limited by fact that some of the survey respondents were not able to estimate the total or break-out some of the components. Of the 36 hospitals in the financial analysis, 27 estimated total Medicaid-related charity and bad debt and 22 (61%) broke out the sub-total for losses absorbed in providing Medicaid uncovered services to children enrolled in Medicaid. The analysis is probably not significantly affected by the missing hospitals since most of the hospitals which did not break out this component of Medicaid-related uncompensated care were in states with more generous eligibility, broader service coverage and/or uncompensated care pools that compensate hospitals which have disproportionately large uncompensated care loads. However, only nine hospitals provided data breaking out the costs of uncovered care for the unenrolled Medicaid eligibles, even though most of the hospitals reported problems with enrollment as having a financial impact (see Chapter VII). For this reason, the data presented on the specific cost impact of enrollment barriers should be considered illustrative. The total losses due to Medicaid-related charity and bad debt are probably underestimated by three to four percent due to this factor alone.

1. Cost of Medicaid Uncovered Services Provided to Medicaid Enrollees

The loss due to uncovered services provided to Medicaid enrollees averaged $1,388,000 for the 22 acute care children's hospitals reporting this uncovered care. Five of these hospitals had losses in excess of $2,000,000 and one lost over $5,000,000 on Medicaid uncovered services. The largest losses were in states that had limits on the number of covered days of hospitalization. For these 22 hospitals, the losses represented almost ten percent (9.6%) of the total cost of care to Medicaid enrollees and increased these hospitals' average Medicaid shortfall from 16.1 percent to 25.6 percent.

2. Uncovered Care Due to Problems Enrolling Medicaid Eligibles

Nine acute care children's hospitals specifically estimated the amount of uncovered care used by Medicaid eligibles which went unpaid because of these eligibles had not enrolled in Medicaid or were unable to provide a valid Medicaid ID. The cost of this care averaged $560,000. Losses specifically from problems in establishing or maintaining enrollment of eligibles equaled 3.6 percent of the total costs of care to the Medicaid eligibles and enrollees served by these nine hospitals. These losses ranged from 0.7 percent to 5.2 percent.

3. Total Medicaid-related Charity and Bad Debt

The total costs of uncovered services provided to Medicaid enrollees and Medicaid eligible-but-unenrolled children resulted in $1.5 million in losses on average for the 26 acute care children's hospitals reporting Medicaid-related charity and bad debt. This entirely uncompensated care comprises 11 percent of the cost of serving the entire population of Medicaid eligibles and enrollees in these hospitals.

4. Total Medicaid-related Losses

Totalling Medicaid-related charity and bad debt losses on uncovered services with the losses from inadequate payment levels brings the total Medicaid-related losses across all 32 acute care children's hospitals to an average loss of $3,560,000 per hospital. Two hospitals had losses of more than $10 million and six others had losses of between $5 million and $10 million.

The average total Medicaid-related loss is 23.4 percent of the costs of patient care for the Medicaid enrolled and unenrolled eligibles in the acute care children's hospitals. This loss, which includes payment level shortfalls and the uncovered care to enrolled and unenrolled eligibles, equals 6.7 percent of total hospital patient care costs for acute care children's hospitals.

It is important to note that this total Medicaid-related loss is underestimated because only one-quarter of the hospitals included the costs for the eligible but unenrolled children and because one-third did not estimate the costs of uncovered services provided to Medicaid enrolled children. The actual loss as a percent of total hospital patient care cost is about one percent larger; as a percent of Medicaid costs it is probably three to four percent larger.

The specialty children's hospitals' total Medicaid losses averaged 5.1 percent of the total costs of care for the enrolled and unenrolled Medicaid group. This represents a loss of 3.0 percent of total patient care costs.

5. Relationship of Medicaid-Related Charity and Bad Debt to Total Hospital Charity and Bad Debt.

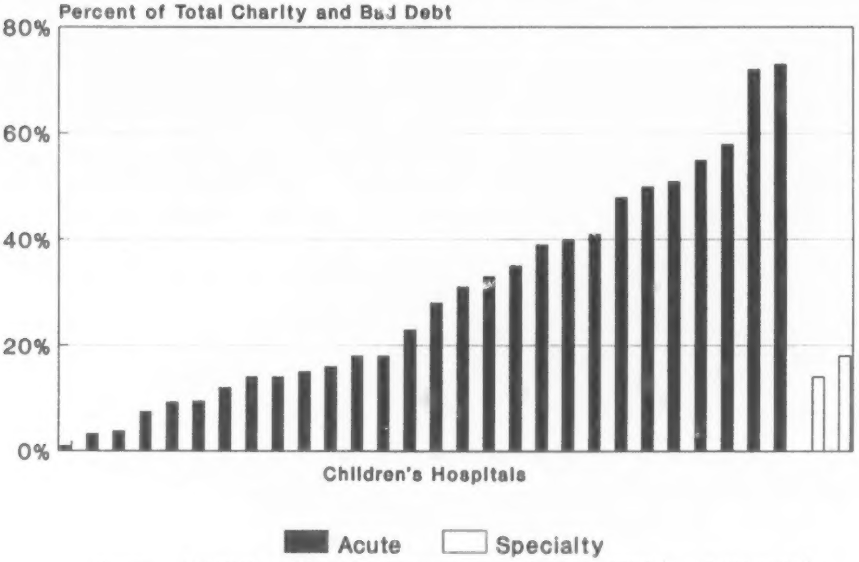
A major portion of the acute care children's hospitals' resources devoted to charity and bad debt are being consumed by Medicaid patients. Among the 26 acute care children's hospitals reporting Medicaid-related charity and bad debt resulting from uncovered charges for Medicaid unenrolled and enrolled eligibles shown in Exhibit VI-6:

- o Medicaid patients in the average hospital used almost one-third (30.7%) of total hospital charity and bad debt resources.
- o Almost one-quarter of the hospitals (23.1%) had Medicaid charity and bad debt loads which consumed more than half of the hospitals' total charity and bad debt resources.
- o Over half of the hospitals (57.7%) devoted more than 20 percent of their total charity and bad debt to Medicaid patients.

The allocation of a major portion of the children's hospitals' charity and bad debt resources to Medicaid children is doubly significant because the typical children's hospital not only has a higher Medicaid load

Exhibit VI - 6

Medicaid Related Charity and Bad Debt as % of Total Charity and Bad Debt



Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

than the average general hospital, but it also provides more uncompensated care. Sixty percent of the acute care children's hospitals exceeded the general hospitals' national average of 6.4 percent of gross revenue in charity and bad debt, as shown in Exhibit VI-7.[17]

The total cost (not charges) of charity and bad debt from uncovered care in the average acute care children's hospital was $4.3 million, of which $1.4 million represented the cost for Medicaid patients.

It is instructive to note that the hospitals which devoted the largest portion of their uncompensated care resources to Medicaid patients were in states which have both limits on covered care and relatively stringent Medicaid income eligibility limits. This suggests that the children's hospitals' capacity to care for poor children who are ineligible for Medicaid and have no health insurance is being seriously eroded because of limitations Medicaid places on the amount of care it finances for Medicaid eligibles.

F. Conclusion

This chapter has shown that children's hospitals absorb large dollar losses on their services to Medicaid children. The losses are problematic because children's hospitals provide a disproportionate share of care to Medicaid patients and charity and bad debt care patients. While these Medicaid losses affect the

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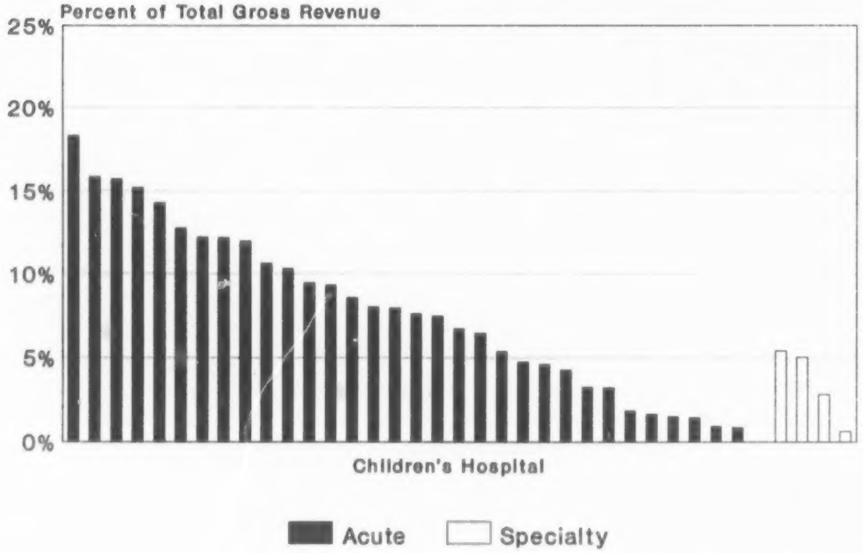
[17] American Hospital Association, unpublished data from the 1987 AHA Survey.

Exhibit VI - 7

Total Charity and Bad Debt As Percent of Total Gross Revenue



Source: NACHRI Medicaid Reimbursement Survey, 1988 (FY 1987 data)

financial stability of children's hospitals, the larger issue is how the underlying problems in Medicaid program design, financing and policy affect children's access to care throughout the health care system.

The chapters which follow illustrate the nature of the problems in the Medicaid program which underlie the large losses absorbed by children's hospitals and the negative consequences of these problems for children's access to health care services. These chapters also address policy options for resolving these inadequacies in the Medicaid program and assuring poor and inadequately resourced children of a decent chance to grow up to be healthy and productive adults.

Chapter VII

Eligibility and Service Coverage

Introduction

This chapter discusses issues, survey results, and policy options regarding problems children and hospitals face because of difficulties in establishing Medicaid eligibility and because of limitations on the services covered by Medicaid. The key findings are:

- Children's hospitals actively assist children and families to enroll in Medicaid. For example, over one-third of children's hospitals have been able to arrange for on-site Medicaid enrollment processing. Many others are willing to support this service, but at least several have been turned down by county or state officials.

- In spite of assistance offered to eligibles, enrollment barriers were reported as causing financial problems for over four-fifths of the children's hospitals.

- About half the children's hospitals reported financial problems because of inpatient and outpatient services which Medicaid does not cover and because of limits on the amount of covered services (eg., only 12 days of covered inpatient care per stay).

- A majority of children's hospitals noted problems with Medicaid HMO/managed care approvals for emergency room care and with retroactive payment denials by Medicaid.

These problems noted by children's hospitals are likely to manifest themselves as access problems for Medicaid beneficiaries in other care settings. Policies to improve access for Medicaid eligibles and ease financial burdens on disproportionate share providers, such as children's hospital, include expanding on-site enrollment in Medicaid, simplifying the application forms, and expanding the range and depth of covered services.

A. Overview of Issues

Barriers to Medicaid enrollment and limits on service coverage can pose significant difficulties for both children and the hospitals treating them. For children, failure to enroll when eligible, limits on covered services, and non-coverage of important health services may mean going without needed care or receiving less than optimal treatment. For hospitals, lack of payment is the usual result when parents fail to complete the enrollment process or fail to maintain enrollment of eligible children. In the case of children who have already been hospitalized and are receiving care, it may be hard to motivate parents to initiate and complete the sometimes arduous enrollment process, since the parents may perceive little direct benefit in obtaining Medicaid coverage.

In the past three years, the Federal government and many of the state governments have made new commitments to expand Medicaid eligibility to a larger portion of the children living in poverty and to break the link between cash welfare assistance and Medicaid. Unfortunately, many states have not coupled Medicaid expansions with active efforts to enroll new eligibles through outreach efforts and removal of financial and administrative barriers to Medicaid enrollment. A recent study sponsored by the Southern Governors' Association found that on average one-quarter of the people applying for AFDC or Medicaid assistance were disqualified, not because of ineligibility, but because they were unable to complete the application process.[1]

Limits on the amount, duration, and scope of Medicaid benefits in some states can result in substantial amounts of uncompensated care. Children's hospitals are especially vulnerable to limitations on benefits because, as centers of excellence in specialized and tertiary care, they attract a sicker population of patients with greater care needs. They also treat a larger proportion of Medicaid patients than other hospitals.

Hospitals are also exposed to financial risk of uncompensated care in providing services to children eligible for Medicaid under the optional medically needy program. Children from families with incomes above the state-set medically needy income level can become eligible for Medicaid by "spending-down" excess income (above the eligibility level) on health care. However, federal spend-down rules require only that the family incur a sufficiently large obligation in order to qualify; the family is not required to actually pay the bill. Medicaid, in turn, is only obligated to cover the bills for care in excess of the spend-down amount.[2]

Hospitals are vulnerable to Medicaid efforts to curb use of emergency rooms for primary and non-emergency care. In many localities, there is an inadequate supply of primary care physicians willing to serve the Medicaid populations. Hospitals in general, and children's hospitals in particular, have traditionally filled the gap and been a major provider of primary care services to the local community. States are now using financial leverage on hospitals to curb what is viewed as inappropriate emergency room use.

Even though institutions such as children's hospitals are strong advocates of continuity of care for children, it is very difficult to break long established care-seeking patterns of the Medicaid population. In addition, federal "anti-dumping" regulations and malpractice concerns require hospitals, at a minimum, to assess or triage every person who seeks care in the emergency room, regardless of whether this represents appropriate or inappropriate care-seeking behavior. The "anti-dumping" rules require hospitals to treat patients in need of emergency care and pregnant women in active labor.[3]

B. Survey Findings

Problems in enrolling in Medicaid and limitations on covered care are potential sources of access problems for poor children and children with major or chronic health care needs. The survey asked children's hospitals about the Medicaid eligibility and service coverage problems affecting them and the children they serve. Since we did not expect the children's hospitals to have significant direct knowledge of the specific access problems faced by Medicaid-eligible children living in areas without a children's hospital or other "open door" providers, we focused many of the questions on the financial impact of potential problems on the children's hospitals. Our primary concern in doing so was to identify health care financing problems that most certainly would result in restricted access for Medicaid-eligible children in other settings as well. Nonetheless, the problems which surfaced also helped to explain why children's hospitals deliver substantial amounts of uncompensated care to children who are entitled to Medicaid.

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[1] "The Relationship of the Reasons for Denial of AFDC/Medicaid Benefits to the Uninsured in the United States."

[2] As a simplified example, if a family's income is $2,500 per month and the state's medically needy income level is $505 per month (about the national average in January 1989), the family is obligated for (i.e., must spend-down an amount equal to) the first $1995 per month; the Medicaid program would pay (at the Medicaid rates) for the services associated with charges in excess of $1995. (In actuality, most states compute the spend-down over a multi-month period. Some states evaluate patient charges at the Medicaid payment rate, effectively discounting billed charges in determining the spend-down and raising the amount of spend-down obligation which the family owes to providers.)

[3] Emergency patients may be transferred to other hospitals, but only after being "stabilized."

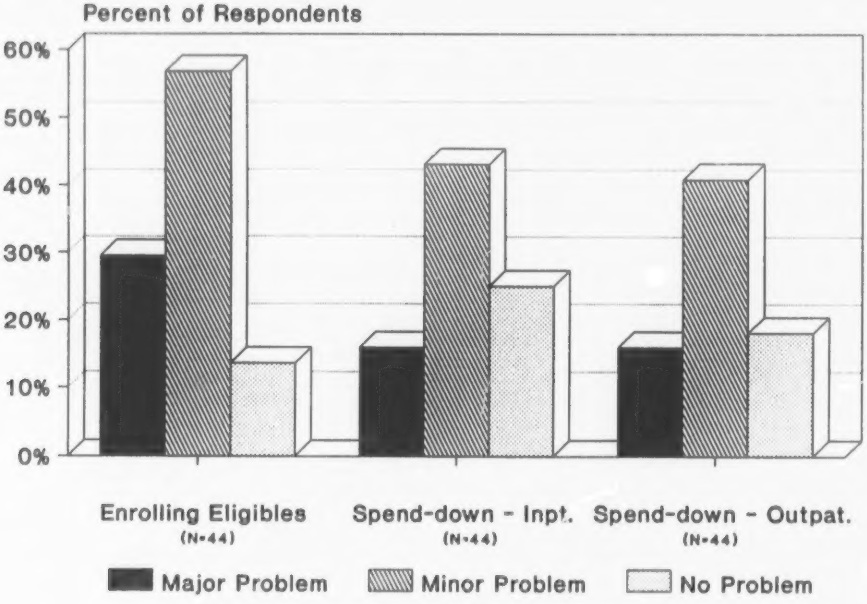
1. Enrollment Issues

Enrollment problems resulting in financial losses were reported by 86.4 percent of the children's hospitals, as shown in Exhibit VII-1. For almost one-third of the hospitals (29.6%), non-enrollment of eligible children was reported as a major reimbursement problem resulting in substantial amounts of uncompensated care.

Many children's hospitals actively assist families of eligible children in enrolling in Medicaid. In addition to motivating parents to apply for Medicaid coverage for their children, the hospitals help to overcome barriers to Medicaid enrollment by sponsoring on-site enrollment or offering transportation to the welfare office, paying for birth certificates, and even providing legal assistance in cases when eligible applicants are rejected.

Exhibit VII - 1

Medicaid Eligibility Issues



Source: NACHRI Medicaid Reimbursement Survey, 1988.

On-site Medicaid eligibility processing is offered for inpatients in over one-third (36.4%) of the responding children's hospitals. Nineteen percent also have on-site enrollment for outpatients. It is not unusual for the hospital to bear the cost of staffing the on-site application process, even when the applications are being taken by state or county employees.

Over three-quarters (76.9%) of the acute care children's hospitals which do not currently have on-site enrollment processing would be willing to support this service financially. Several of these hospitals have attempted to arrange for on-site eligibility processing, but have been turned down by state or county officials. In one state, the Medicaid officials will not even allow the hospitals to have copies of the application form.

In spite of efforts to ease the enrollment barriers and help children access Medicaid and, thus, care in all settings, many hospitals cited the extreme complexity of applying for Medicaid from the potential eligible's perspective as one of the five most pressing eligibility problems. Specific comments from children's hospitals included:

- The information burden on applicants is so great that many potential eligibles fail to apply or fail to complete the application process due to their inability to complete the complex forms. For example, the application form in Michigan is 32 pages, presenting a difficult application process for even the most motivated applicant.
- Medicaid case workers are frequently overworked, undertrained, and, in some cases, not motivated to provide the assistance needed by potential eligibles.
- Medicaid takes too long to process applications and provide a Medicaid number for billing purposes. This puts the hospitals in the undesirable situation of having to stay in contact with the patient, in case further information is needed to complete the application process, and having to delay billing.

It is important to note that for the Medicaid applicants, the delay in obtaining a Medicaid card can result in problems of access since many providers, such as pharmacies and private practice practitioners are likely to view those without a valid Medicaid card as uncompensated care patients.

In addition, the children's hospitals often felt that the income limits for eligibility are too low and serve as a significant barrier to needed care. Several hospitals in areas with significant resident alien populations expressed concerns about the Medicaid eligibility procedures and service coverage for aliens.[4]

2. Medically Needy Spend-Down

Uncompensated spend-down obligations for medically needy eligibles is perceived as a frequent, but not severe problem (see Exhibit VII-1). Over half of the respondents reported spend-down as a problem for inpatients and outpatients. Spend-down was rated as a major problem by 15.9 percent of the hospitals.

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[4] Although Medicaid must cover eligible illegal aliens for emergency care, effective October 1, 1988, all Medicaid applicants must declare in writing, under penalty of perjury, that they are citizens or aliens in a satisfactory immigration status. The Medicaid agency is required to verify immigration status with the Immigration and Naturalization Service. Illegal aliens who have applied for legalization can receive Medicaid, but coverage is limited to emergencies and pregnancies unless the person is under age 18, a Cuban-Haitian entrant, or aged, blind or disabled under the SSI program. (Source: Medicaid Source Book, p. 88-89.)

These figures tend to understate the problem, since about one-third of the states do not offer medically needy eligibility in their Medicaid programs.

Children's hospitals in states with medically needy programs often cited excessive spend down requirements as one of the five most significant problems affecting eligibility and service coverage. They suggested that a cap on the spend down amount should be established.

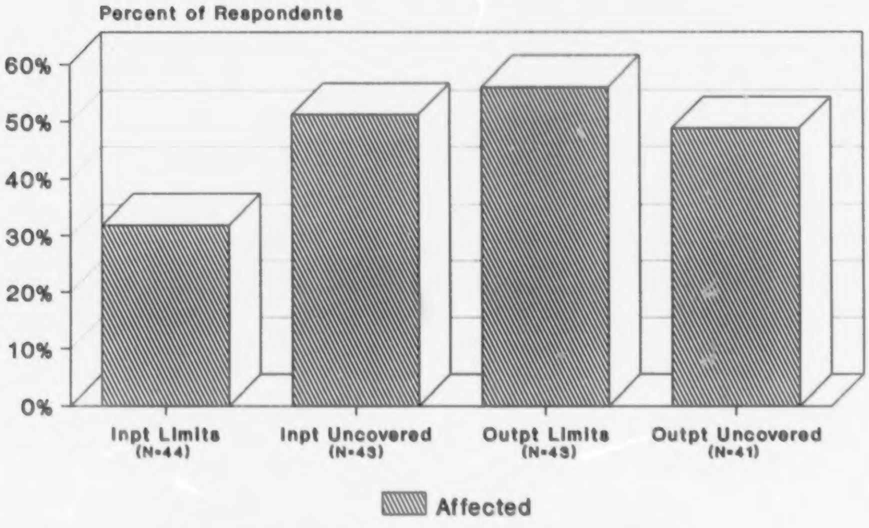
3. Uncovered Services

About half of the responding children's hospitals are affected by services Medicaid does not cover. Uncovered services exist because states can elect to exclude services from coverage or to limit the volume, duration or annual total payment for covered services. Uncompensated care to Medicaid patients also results from excessively stringent prior approval requirements and medical necessity criteria.

Limits on the number of inpatient days were reported as affecting almost one-third (31.8%) of the hospitals (see Exhibit VII-2). Typically the limits apply to the number of days covered per stay or per year for an individual. For example, Alabama generally covers only the first 12 days in a stay. Illinois Medicaid limits the aggregate number of inpatient days provided by each hospital each year.

Exhibit VII - 2

Medicaid Coverage Issues
Affecting Children's Hospitals



Source: NACHRI Medicaid Reimbursement Survery, 1988.

The impact of day limits on children's hospitals can be very severe. An independent study commissioned by the children's hospitals of Texas attributed half of the aggregate hospital losses in serving Medicaid patients to the 30 day/$50,000 per year inpatient benefit limitation. NACHRI research has shown various states' Medicaid day limits to result in from 10 to 50 percent of Medicaid pediatric inpatient days being uncovered. A major concern about such limits is that they are likely to limit access for those children with the greatest needs.[5] Every hospital affected by day limits cited the problem as one of the five most significant negative factors affecting the hospital and the children.

Non-coverage and/or extremely restrictive medical criteria for specific inpatient services were reported as problematical by 51.1 percent of the children's hospitals. The most commonly uncovered or restricted inpatient services are rehabilitation, psychiatric care, treatment for eating disorders, ground and air transportation, and organ transplantation.

Many children's hospitals also cited non-coverage of protective or "administratively necessary" days as problematic. These are extended days of inpatient stay necessitated by the inability to discharge a child because that child has no place to go. This includes abandoned children and those whose parents are unable to provide for the child's care needs. In these cases, although the hospital is acting to safeguard the health of the child and working with the appropriate state agencies to find proper placement for the child, some Medicaid programs will not pay for the extended stay. This problem is likely to become more pressing as the number of abandoned AIDS babies and those born with drug-related problems increases.

Limited outpatient benefits were reported by one-half (51.2%) of the respondents. Examples of such limits include:

- Four visits per month in Ohio and Missouri and three per year in Alabama.
- $1000 of outpatient care per year in Florida.
- One visit per day in the District of Columbia.

Just under half of the hospitals (48.8%) reported that important outpatient services were not being covered by Medicaid. Examples of the outpatient services most often cited by hospitals as not covered or excessively restricted included:

- Durable medical equipment for home care use
- Home care services
- Occupational therapy
- Physical therapy
- Audiology
- Outpatient pharmacy
- Speech therapy
- Psychiatric services
- Dental services
- Nutritional counseling

Such limits and exclusions affect children's access to care, particularly those children with chronic or complex acute conditions. These exclusions may act as disincentives to more appropriate and less expensive outpatient or home care. For example, Pennsylvania's exclusion of antibiotic infusion therapy at home was cited as resulting in extending inpatient stays for Medicaid patients with cystic fibrosis one week beyond the typical stay for insured patients.[6]

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[5] In a recent court decision, the Texas dollar limit was found to illegally deny care to two children needing liver transplants. Source: Veilia Montoya v. Marlin W. Johnston, U.S. District Court, Western District of Texas, 654 F.Supp. 511, Feb. 23, 1987.

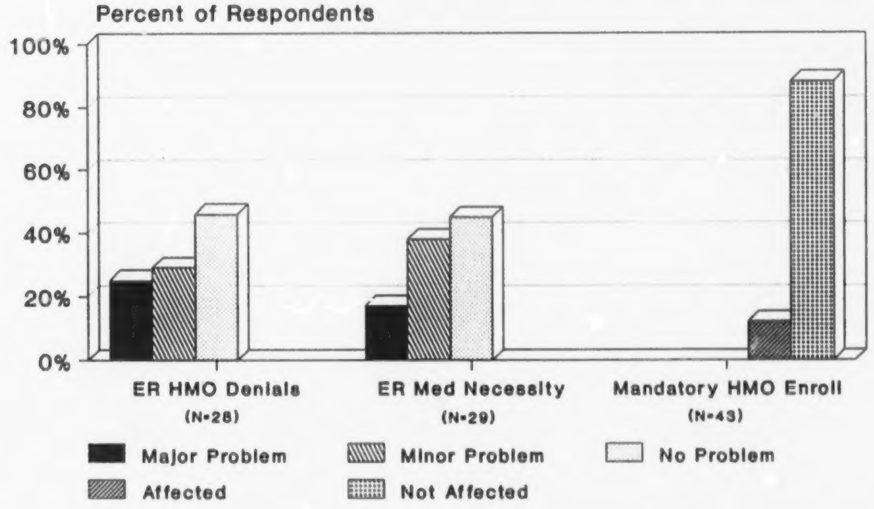
4. Restrictions on Emergency Room Use:

Many Medicaid programs have sought in recent years to cut the costs associated with inappropriate use of emergency room (ER) care for non-emergent conditions. The most common approaches have been to use HMOs and managed care programs as gatekeepers or to retroactively deny or reduce payment for non-emergency services provided in ERs. This has caused problems for children's hospitals and other hospitals because these health plans have not been sufficiently effective in changing care seeking behavior and the hospitals find it difficult, if not medically inappropriate, to turn away sick children in need of care.

Medicaid HMO and managed care plan denials of payment for ER care in children's hospitals were cited as problems by over half (58.8%) of those responding to the question (see Exhibit VII-3). Problems with

Exhibit VII - 3

Emergency Room and HMO Issues Affecting Children's Hospitals



Source: NACHRI Medicaid Reimbursement Survey, 1988.

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[6] "Medicaid and Poor Children," p. 72.

retroactive payment denials on the grounds of medical necessity were also noted by over half (55.2%) of the hospitals responding to this item.

One problem noted by survey respondents is that Medicaid recipients in managed care plans often do not understand the rules and restrictions to which they agreed when they enrolled. As a result, they often inappropriately utilize services (ie., without care manager approval) and the hospitals providing the care then find it exceedingly difficult, if not impossible, to obtain payment for the services provided. This problem is likely to be exacerbated in localities where Medicaid enrollees have been involuntarily enrolled in HMOs and other managed care plans. Fortunately, mandatory enrollment in HMOs is not widespread at this time. Only five hospitals reported enrollment in HMOs or Managed Care Plans as mandatory.

A related problem for hospitals is the financial instability of some of the HMOs and managed care plans to which Medicaid enrollees have been involuntarily assigned. Several of these have gone bankrupt, creating major access problems for the Medicaid enrollees and large amounts of bad debt for the hospitals and other care providers.[7]

C. Policy Options:

Steps which could potentially improve access to Medicaid and simplify enrollment include:

- Federal financial incentives for states to implement outreach programs and provide on-site enrollment in high volume locations;
- Requirements on states to establish on-site enrollment when requested by health care providers;
- Simplification of applications requirements and forms;
- Elimination or liberalization of asset tests (because they exclude needy children and add significantly to the application form length and processing time); and,
- Lifting the medically needy income eligibility ceiling and capping the spend-down at a percentage of family income;
- Establishment of presumptive eligibility for children.

The ultimate solution to the problem of unresourced children would involve automatic, universal health care coverage, most likely through a combination of employer-sponsored insurance and government-subsidized or operated coverage for the remaining population.

The medically needy program's income eligibility criteria remains directly linked to eligibility for AFDC cash welfare assistance. States can not raise eligibility above 133 percent of the welfare income level, resulting in excessive spend-down requirements for families of modest means. Limiting the amount of spend-down to a percentage of family income (which would vary by income and family size) and easing disposal of asset requirements would improve access to Medicaid and reduce the amount of uncompensated care given by hospitals and other providers.

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[7] Access problems for Medicaid beneficiaries due to pharmacies discontinuing services were reported in the wake of the insolvency of Maxicare and termination of payments by its subsidiary Medicaid plan in Philadelphia known as HealthPASS/Penn Health. Following its filing for protection under Chapter 11 of the federal bankruptcy laws, the health plans checks began to bounce. The Children's Hospital of Philadelphia, the largest participant in the plan that served 85,000 Medicaid beneficiaries, continued to provide services although it was owed $3 million. Source: Philadelphia Inquirer, April 3, 1989, p. 1.

Initial steps towards removing inpatient benefit limitations were begun in 1988 with the passage of federal legislation requiring states to eliminate day limits (and pay adequately for exceptionally long and costly stays) for infants in disproportionate share hospitals. Expansion of these requirements to older children would improve access to care and ease financial burdens on most children's hospitals and other hospitals providing a disproportionate share of these services.

Other policy options to improve children's access to needed health care services include:

- Federal requirements that states cover a broader package of services (for all children or for selected groups, such as disabled and chronically ill children);
- State-level initiatives to broaden service coverage and eliminate limitations for children; and,
- Establishment of federal and state policies which assure adequate and continuing access to care for Medicaid enrollees in managed care plans and which preserve the beneficiaries rights to freedom of choice of provider.

Chapter VIII

Inpatient Reimbursement Methods and Rates

Introduction

This chapter describes the inpatient payment methodologies which were being used by Medicaid programs to reimburse children's hospitals as of October 1988. The key findings are:

- The large majority of children's hospitals (83.7%) were reimbursed under prospective payment systems of various types.
- Many of the children's hospitals noted that the payment rates failed to reflect the costs associated with specialized pediatric patient populations and/or the rate of inflation in the costs incurred by hospitals.
- One-quarter of the children's hospitals noted that potential Medicaid losses had forced them to postpone offering new services or to curtail expansion of existing services.
- Although virtually all of the children's hospitals responding to the survey appeared to meet the federal Medicaid law definition of a disproportionate share hospital, over one-third had not been designated as disproportionate share hospitals as of October 1988, in spite of federal law requiring implementation on July 1, 1988.
- Almost half of the children's hospitals believed that inpatient payments would improve because of recent federal legislation on disproportionate share payments, benefit improvements and outlier payments for infants in disproportionate share hospitals, and/or revisions in state payment policies.

Several policy initiatives are needed to foster more adequate reimbursement and to ensure access for children, including: (1) expansion and/or strengthening of recent federal legislation on disproportionate share, inpatient benefit improvements, and outlier payments; (2) development and use of improved pediatric case mix classification and payment policies; and (3) development and enforcement of payment adequacy standards by HCFA.

A. Overview of Issues

The adequacy of Medicaid reimbursement for Medicaid-covered inpatient care can profoundly affect the children's hospital's ability to serve not only the Medicaid population, but ultimately all children.

In addition, while children's hospitals and other hospitals have shown a commitment to serving large numbers of Medicaid-eligible children and absorbing large losses, the burden is not equally shared by all providers. To the extent that payment rates and methods lead to inadequate payment, they have the potential to affect children's access to care within the whole health care system. Although this analysis focuses on methods used to reimburse children's hospitals, many of the observations most likely apply to the entire hospital "industry".

Since 1981, states have had very broad latitude to select inpatient reimbursement methodology and set payment levels. Most states have chosen to use the flexibility granted in 1981 to move from cost-related reimbursement to some form of prospective payment so that, as of August, 1987, only eight jurisdictions used retrospective cost reimbursement.[1] As of January 1989, 17 of the 42 Medicaid programs with prospectively set payment rates used an approach similar to Medicare PPS, employing Medicare DRGs or a state-developed illness classification system on which to base the amount of payment per discharge.[2]

In theory, a well designed prospective payment system financially rewards "efficient" hospitals with profits, penalizes the inefficient hospitals with losses, and generates savings in state spending for care. Many questions remain to be answered regarding whether such systems can or actually do produce these intended benefits.

Many states have implemented very simplistic prospective payment systems which appear to be motivated more by a desire to limit state expenditures for care than by an intent to provide incentives and rewards for efficiency. In order for a prospective payment system to meet minimal criteria for adequacy and appropriateness, it must reflect the differences among hospitals, such as in case mix, severity of illness, commitment to medical and allied health professions education, and stand-by capacity. It must also keep pace with the financial requirements of hospitals imposed by external considerations, such as supplier price increases, personnel wage increases (especially for nurses) advances in medical technology, and the costs of caring for new kinds of illnesses (eg., HIV safety procedures). The outlier payment policies in Medicare PPS provide a strong disincentive to admitting patients who are sicker than the average patient within the DRG. Hospitals which serve a disproportionate number of very sick and costly patients are at systematic risk of financial losses under PPS.

The system should also provide appropriate incentives regarding appropriate resources for different groups of patients, including the choice between inpatient and outpatient care. For example, payment systems which pay a single amount per discharge give a hospital very strong incentives to admit minimally ill patients (who might be better served as outpatients) and to exclude those who will require extensive, costly care.

Children's hospitals and other specialized, tertiary care providers are very vulnerable to prospective payment systems, even those which are well designed to reflect the different costs of different groups of patients and to reward efficiency in the average community hospital. "State-of-the-art" prospective payment systems use Diagnostic Related Groups (DRGs) to categorize patients according to typical resource use and provide various special payment adjustments to compensate for differences in outlier cases, medical education, and input prices. Research conducted by NACHRI and others has shown that even these sophisticated systems do not sufficiently compensate for the resources required to treat the complicated illnesses presenting in children's hospitals or the special staffing, supply and equipment required to serve a pediatric population.[3]

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[1] "Medicaid Source Book," pp. 124-5.

[2] Susan S. Laudicina, "State Systems for Hospital Payment," Intergovernmental Health Policy Project, The George Washington University, Washington, D.C., April 1989, pp. 3-4.

[3] Leo Lichtig et al., "Refining DRGs: the Example of Children's Diagnosis-Related Groups," Medical Care, Vol. 27, No. 5 (May 1989), pp. 491-504; John Langenbrunner et al., "Developing Payment Refinements and Reforms under Medicare for Excluded Hospitals," Health Care Financing Review, Vol. 10, No. 3 (Spring 1989) pp. 91-107; "The Children's Hospitals Case Mix Classification System Project: Phase III Report", NACHRI, Alexandria, Virginia, September 1986; Susan Payne and Joseph Restuccia, "Options for Paying Children's Hospitals on a Prospective Basis," Brandeis University, Waltham, Massachusetts, March 1985; Michael Long, Janice Dreachslin, and James Fisher, "Should Children's Hospitals Have Special

The commitment of adequate state funds to the payment system is a very important issue. An under-funded system, no matter how well designed, will impose financial hardship on a majority, if not all, hospitals serving the Medicaid population. Under-funding of prospective payment systems is usually accomplished by one of the following methods:

- Budget "neutrality" adjustments, which reduce rates to the point that the total projected payout equals the amount the state wishes to spend; or
- "Update factors," which are supposed to increase rates to keep pace with medical technology and with inflation in the goods and services hospitals purchase, may instead be set to equal the increase in spending which the state is willing to fund.

Even cost-based reimbursement systems can be under-funded by setting limits on the amount of reimbursement per day or per discharge, applying inadequate annual update factors, or restricting the costs which are reimbursable.

At least part of the pressure on states to under-fund their Medicaid inpatient payment systems comes from HCFA. Under a general legislative authority requiring economy of operation in Medicaid, HCFA limits the annual increase in states' Medicaid spending per recipient of inpatient care. HCFA sets this per capita Medicaid spending limit equal to the update factor used for the per discharge base rate in the Medicare Prospective Payment System.[4] The actual rate of payment increase in Medicare has historically been much higher than the update factor. In addition, HCFA has not established any procedures or criteria for enforcement of the Medicaid legislative requirement that Medicaid rates "meet the costs of efficiently and economically operated" hospitals.

Children's hospitals are particularly vulnerable to under-funding of Medicaid because a high proportion of their services are consumed by the Medicaid population. Inadequate Medicaid payment results in shortfalls which must be covered, in part, by raising charges to other patients. But raising prices to make up for Medicaid losses puts a hospital at a competitive disadvantage relative to other hospitals which chose to limit their Medicaid utilization. As payor demands for discounts and loss of volume in response to higher charges lead to a loss of adequately paying patients, the hospital becomes even more dependent on Medicaid, creating an even greater competitive disadvantage.

In response to the problem of inadequate Medicaid payment to high Medicaid volume hospitals, the Congress in 1987 enacted new requirements for states to make additional payments to hospitals with a disproportionate share of Medicaid patients. In very simple terms, Medicaid programs must make disproportionate share payments to every hospital whose total load of Medicaid, charity and government subsidized patients exceeds 25 percent and every hospital whose Medicaid load places it in the top one-sixth of hospitals statewide, as measured by the percent of total inpatient days used by Medicaid

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Consideration in Reimbursement Policy?" Health Care Financing Review, Vol 8, No. 1 (Fall 1986) pp. 55-63; Ronald Poland et al., "Analysis of the Effects of Applying Federal Diagnosis-related Grouping (DRG) Guidelines to a Population of High-Risk Newborn Infants, Pediatrics, Vol. 76, No. 1 (July 1985) pp. 104-109.

[4] These limits are often called TEFRA limits, as they are modeled on the TEFRA statute limiting payments for Medicare patients in PPS-exempt hospitals.

patients.[5] States were required to implement disproportionate share payments as of July 1, 1988 and were given discretion in the amount of the disproportionate share payment and in designating additional hospitals as disproportionate share providers.

B. Survey Findings

This section addresses the methods and rates of payment that were in effect as of October 1988 and identifies features which may result in inadequate reimbursement or inappropriate incentives. (The reader should be aware that the analysis of Medicaid shortfalls in the previous chapter examined payment adequacy in the prior year, 1987.)

The bulk of the presentation addresses only the reimbursement methods used for the acute care children's hospitals, unless otherwise noted. Brief coverage is given to the reimbursement methods used for the specialty children's hospitals, since they tend to be rather unique institutions and often have developed special Medicaid reimbursement arrangements reflecting their unique patient populations and services.

1. Payment and Prospectivity for Specialty Care Children's Hospitals

Of the five specialty care children's hospitals responding to this section, two receive cost-based reimbursement with interim payments set as a percent of charges in one case and a flat per discharge amount in the other. The other three are paid prospectively set rates which are set on a per discharge basis in two cases and as a percent of charges in one. Four of the five receive interim payments, which are critical to cash flow when caring for patients who typically have very long stays. Two of the hospitals have been designated as disproportionate share, two are awaiting designation, and one is in a state that operates an alternate system under one of the special exemptions.

The remainder of this section addresses acute care children's hospitals exclusively.

2. Unit of Payment for Acute Care Children's Hospitals

The unit of payment used by Medicaid for acute care children's hospitals varies widely, as shown in Exhibit VIII-1. The most common payment units are the flat rate per day (31.8%) and DRG-based per discharge payments (31.8%). These are followed by per diems which vary by inpatient care unit (18.2%) and a flat rate per discharge (9.1%). Only 6.8 percent of the hospitals are paid a percentage of charges.

The flat rate, prospectively set payments are the least sensitive to the needs of individual patients and may be perceived as setting inappropriate incentives for a tertiary care hospital by rewarding admissions of moderately ill patients and producing large losses on the admissions of very sick patients.

3. Prospectivity of Payment Rates

Prospective payment rates, which are set in advance and not adjusted to reflect a hospital's actual costs for the year, are the dominant mode of Medicaid payment. The vast majority of acute care children's hospitals (83.7%) reported fully prospective rates being used by Medicaid (See Exhibit VIII-2). Partially prospective rates were used for seven percent (3 hospitals), meaning that the rate can be adjusted for

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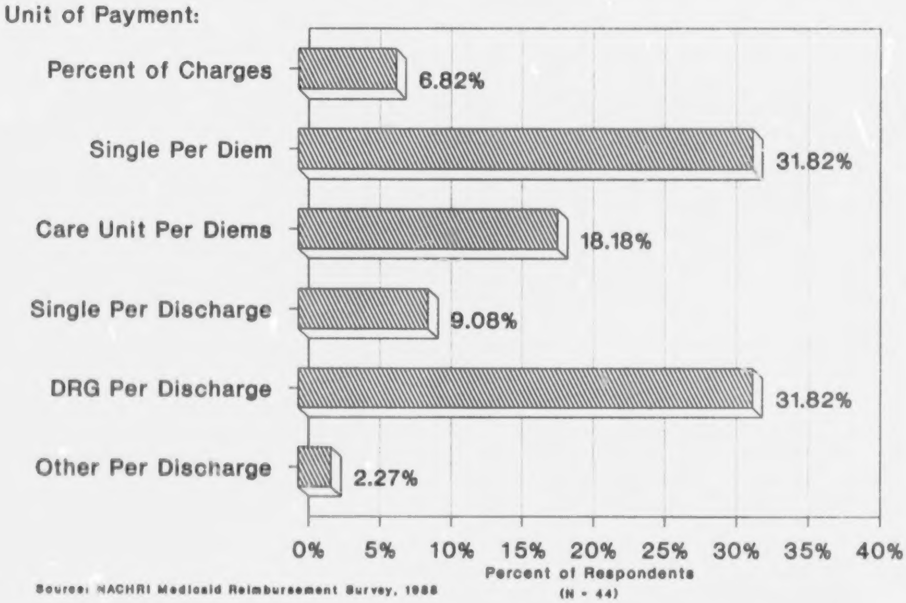
[5] Two states which had previously implemented disproportionate share payments (Texas and New York) were exempted from the statutory definition so long as they continue to meet certain requirements.

Exhibit VIII - 1

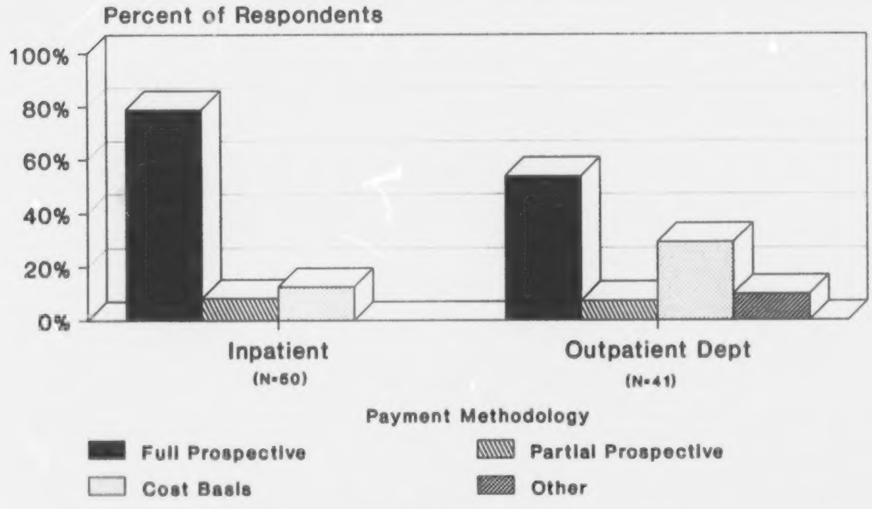
Unit of Payment for Inpatient Services in Acute Care Children's Hospitals



Source: NACHRI Medicaid Reimbursement Survey, 1988

Exhibit VIII - 2

Prospectivity of Medicaid Payment for Inpatient and Outpatient Services



Source: NACHRI Medicaid Reimbursement Survey, 1988.

actual costs or other factors on a retroactive basis. For one of these hospitals, there is only a downward adjustment if costs are lower than the pre-set rate. Cost-based reimbursement (with interim payments and retroactive settlement to cost) was used for only 9.3 percent (4 hospitals).

4. Aspects of Prospective Payment Systems

A key consideration in any payment system is how accurately and adequately the basic payment rate reflects the financial requirements or other appropriate basis for compensating efficiently operated institutions which meet quality of care standards.[6] While the analysis below examines this issue in terms of how rates were developed, the real issue is whether the resulting rates and the actual aggregate payments are adequate and appropriate.

In responding to a question about the most difficult features of their state's Medicaid payment system, many of the children's hospitals noted that:

- Payment rates do not reflect the uniqueness of children's hospitals or they severely underestimate the cost associated with pediatric patients, particularly neonates.
- The payment base rate is not updated often enough.
- The factors used in the updating are inappropriate, inadequate or driven more by a state's need to meet budget neutrality. For example, the rapidly increasing costs associated with the nursing shortage and high technology are not considered.

Most of the states which use DRG payment systems modeled on Medicare as the basis of paying for individual patients' care have recognized that this system is inappropriate for their free-standing children's hospitals.[7] These states have either exempted the children's hospitals (for example, New York, Colorado, Utah, and most recently, Texas) or they have made significant alterations (for example, Ohio and Pennsylvania).[8,9]

One feature of prospective payment systems that deserves special examination is how they pay for "outliers," those patients with unusually long or costly stays. For per discharge payment systems lacking outlier payments, both long stay and high cost patients would be under-compensated, particularly in flat rate systems. Two of the six DRG PPS states represented in the survey have no cost outlier provisions and one has no long stay outlier provisions. For the three states with flat per discharge systems, two provide outlier payments. However, the Georgia cost outliers are set so high as to be almost meaningless: for one hospital, the loss has to exceed $420,000 before an outlier payment is made.[10]

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[6] Payment by a single payor at rates less than full financial requirements might be quite adequate in a state with a good uncompensated care pool or other means of funding costs excluded from reimbursement for services.

[7] Children's hospitals are exempt from Medicare PPS.

[8] At the time of the survey (October 1988), Texas included its children's hospitals in its DRG PPS. Thus, Texas is included as a DRG PPS payment system in the analysis, even though the children's hospitals of Texas are no longer reimbursed under the DRG payment system.

[9] The Department of Defense's CHAMPUS PPS addresses the special payment policy issues arising from the systematic risk due to the high proportion of outlier and catastrophic cases in children's hospitals and the different staffing and cost requirements of children's hospitals by: (1) using a the neonatal portion of the Pediatric Modified DRGs in lieu of Medicare neonatal DRGs, (2) applying special outlier definitions and payment policies, and (3) employing a special adjustment to the ASA (i.e., the standard payment amount per case).

In per diem prospective payment systems there is no need for long stay outlier payments, but cost outliers are an issue, particularly for patients needing very complicated interventions. Prospectively set per diem rates also provide a disincentive to lowering costs through shorter stays, particularly when there are no cost outlier payments. Only one of the 12 prospective per diem rate states represented in the survey provides additional payments for very costly patients.

Prospective payment systems are thought to be inappropriate for certain categories of patients. This is particularly true in DRG systems for certain groups of patients, such as rehabilitation patients, where diagnosis does not provide a basis to predict average resource consumption. Five of the six DRG states have exempt categories, while only half of the per diem systems have any exemptions. The situation is very similar for psychiatric patients.

DRG-based and other payment systems that pay only upon discharge can pose a significant cash flow problem for tertiary care and other providers who serve long staying and high cost patients. Periodic interim payments or a provision for interim billing for these patients is permitted in 12 of the prospective payment states.

5. Limits on Payment Rates

It is not uncommon for Medicaid programs to limit payment rates relative to the historical costs of a hospital or a peer group or relative to the payments or volume of care for the hospital in a prior year. Just over one-third of the respondents (34.9%) noted that they are subject to ceilings on payment per day or per discharge or to limits on the total aggregate number of days of care which may be provided to Medicaid patients.

6. Impact of Inadequate Medicaid Payment on Access to Care

Medicaid payment shortfalls have the potential to create access problems for both the children who are the beneficiaries of the Medicaid program and for other children in need of services which hospitals cannot afford to provide because of excessive Medicaid losses.

Medicaid payment shortfalls were noted as concentrated in certain categories of patients, according to a majority of the respondents (60.5%). Neonatal intensive care was the most frequently mentioned service affected by inadequate payment, but many other services were also noted.

The payment shortfalls have led more than one-quarter of the hospitals (28.6%) to postpone offering new services or to curtail expansions of existing services because of their potential for adding to Medicaid losses. Trauma care, bone marrow and other transplant services and respite care were most frequently mentioned.

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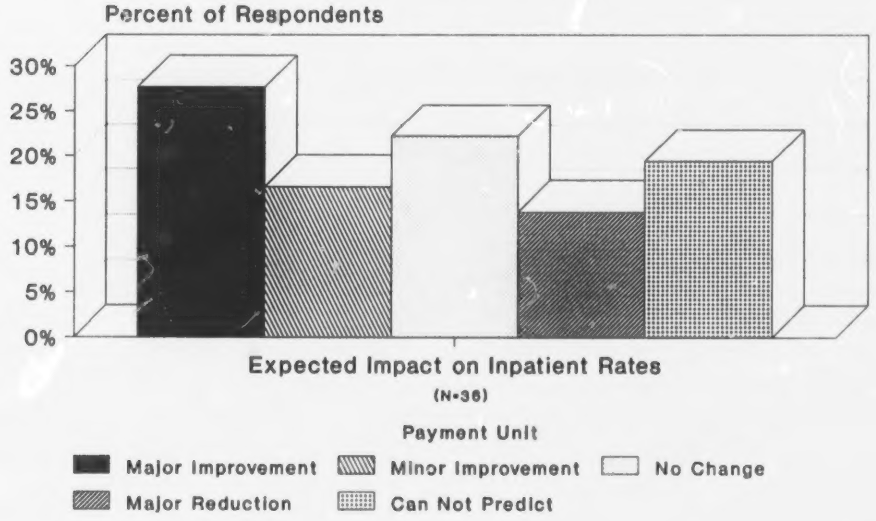
[10] The Georgia legislature has subsequently enacted legislation to liberalize the outlier payment provisions.

Exhibit VIII - 3

Expected Impact of New Payment Changes on Inpatient Rates



Source: NACHRI Medicaid Reimbursement Survey, 1988.

7. Disproportionate Share

Over half of the respondents (56.8%) had been designated as disproportionate share hospitals at the time of the survey. Although states were required by law to have their disproportionate share payment systems operational by July 1, 1988, 34.1 percent of children's hospitals reported that their state had not yet made formal disproportionate share designations, possibly because they were awaiting HCFA approval of their disproportionate share plans. Four hospitals (9.1%) reported that they had not qualified. In two cases, the hospitals reported that their Medicaid inpatient day percentages of 16 percent and 39 percent were too low; in the third case, the hospital noted that an exemption from the regular Medicaid payment system also exempted the hospital from disproportionate share payments.

8. Expected Impacts of Anticipated Changes in Inpatient Reimbursement

Changes which are now being made or which are likely to be made in their state's Medicaid payment system in the coming year were seen as leading to improved inpatient payments by a significant proportion of children's hospitals (see Exhibit VIII-3). Over one-quarter (27.8%) expected a major improvement and another 16.7 percent felt that minor improvements were likely.

The most common explanation for expected improvements included:

- Disproportionate share payments

- Elimination of day limits and better outlier payments for infants in disproportionate share status hospitals
- Returning to cost-based reimbursement in two states
- Rebasing of rates
- Revised outlier thresholds
- Better update factors

Although many of the hospitals were optimistic, a few expected major declines.

The big unknown at this time is the impact of the mandatory eligibility expansions scheduled to be implemented in July 1989 and thereafter. Several states appear to be expanding eligibility and services at the expense of hospital reimbursement through a "budget neutrality" adjustment to hospital payment rates. In other words, hospitals are being required to finance the additional services which will be used by the new Medicaid beneficiaries. Maintenance of effort is critical to avoid deterioration in already inadequate reimbursement levels.

C. Policy Options

There are many complex issues in developing payment methodology policies that can assure adequate and appropriate reimbursement to preserve access to the quality services needed by Medicaid children. As noted in the previously, a significant part of the payment adequacy issue is actually one of service coverage.

Probably the most important policy consideration in payment adequacy is the commitment of adequate resources to the Medicaid program. But this is really an issue of political willingness at the state level and probably not very amenable to improvements in federal policy. Federal legislation authorizing court-ordered receivership, such as in extreme and unusual cases of imminent harm to beneficiary access, could possibly put pressure on states. As a stopgap measure, hospitals and others should continue to be allowed to volunteer funds to Medicaid to keep the program afloat.

Maintenance of current effort and improvement in states with seriously under-funded reimbursement systems could be achieved through enforcement of the federal law requiring Medicaid payments to hospitals to meet the costs of efficiently and economically operated hospitals.

The other general types of policy initiatives needed to move towards adequate reimbursement and to assure that children have access to needed care include:

- Strengthening disproportionate share payment requirements by relating the amount of payment to the financial requirements of the disproportionate share hospitals;

- Strengthening and expanding to all children the recently enacted requirement for adequate outlier payments in the case of infants in disproportionate share hospitals;

- Providing more appropriate incentives and rewards for efficiency (for example, by developing modifications to DRG case mix classification and outlier policies to better reflect pediatric resource consumption); and

- Developing enforceable standards of payment adequacy which reflect the financial requirements of disproportionate share hospitals and requiring HCFA to enforce and periodically report to the Congress on the adequacy of Medicaid payments to hospitals.

Chapter IX

Outpatient Payments

Introduction

This chapter describes the methods and rates used to compensate hospitals for outpatient services, including emergency room care and outpatient surgery. The key findings are that:

- o Over two-thirds of the children's hospitals are reimbursed under prospective payment rates which they reported as bearing little relationship to current costs.
- o One-quarter of the children's hospitals noted that they found it necessary to postpone offering or restrict certain outpatient services because of their potential to add to Medicaid losses.

Because hospital outpatient services are essential to ensuring access to care for many Medicaid beneficiaries, it would be appropriate to apply existing Medicaid inpatient policies on disproportionate share payments and payment rate adequacy to hospital outpatient care.

A. Overview of Issues

Outpatient payment policy in Medicaid is very much the neglected sibling of inpatient payment policy. Yet, for children's hospitals and the children who they serve, outpatient reimbursement is a significant issue.

The children's hospitals' have a dual role -- service to children and educating physicians in pediatrics -- which is essential to both the current and future well-being of children. The children's hospitals' capacity to fill these roles is intricately linked to Medicaid payment policy for outpatient care.

It is the philosophy of children's hospitals (and a conclusion supported by developmental research) that children belong with their families and should not be hospitalized if other alternatives are available. Yet, the payment policies of many Medicaid programs provide very strong financial disincentives to serving children in the outpatient setting. Such policies may cost Medicaid more money if they result in additional hospital admissions. These disincentives also run counter to the graduate medical educational priorities in the training of pediatricians for primary care and for most pediatric specialties as well.

It is common in many Medicaid programs to pay for outpatient care, including emergency room services and outpatient surgery, under fee schedules or with payment limits on cost-related reimbursement. Underlying this practice is a point of view which asserts that, because the care delivered in outpatient settings is similar to the care delivered in physicians' offices or ambulatory surgical centers, it should be compensated at a similar level. This view point is flawed, in that it fails to recognize key differences in patient population and severity of illness, the infrastructure supporting outpatient care, and the teaching mission. The cost accounting conventions used for cost-based reimbursement, which Medicare and Medicaid have required hospitals to use, also contribute to the differences between the costs of hospital outpatient services and the rates paid to physicians and ambulatory surgical centers.

The concept that outpatient care should be price competitive with physicians' office care is equally flawed from a public policy perspective. The Medicaid and charity care patients, who are the most prominent users of primary care services in outpatient settings, are not price-sensitive. Overly price-sensitive Medicaid outpatient payment policies are likely to lead hospitals to close or constrict their outpatient services. The result of inadequate Medicaid payments for outpatient care may well be less access for those children who are most dependent on hospital-based care.

Finally, it should be noted that Medicaid fee schedules for physician office visits and other outpatient services are often very, very low -- sometimes to the point of discouraging provider participation. This compounds the problem of linking hospital based outpatient payment rates to the fee schedules for these other services.

B. Survey Findings

The survey data reflected the status of outpatient payment policies affecting children's hospitals as of the Fall, 1988.

1. Payment Rates for Outpatient Department (OPD) Services

The majority (54.6%) of children's hospitals are paid a percentage of charges for OPD visits, usually bearing some relationship to cost, either actual or historical. One-quarter (27.2%) are paid a flat rate per visit. The remainder are paid either rates that vary with the type of visit or clinic or according to a fee schedule. Per visit payments reported by children's hospitals ranged from a high of $103 to a low of only $17.

One reason for low OPD payments is that many of the children's hospitals are subject to prospectively set rates that were reported to have been set arbitrarily or not adjusted for inflation. Sixty-one percent of the hospitals reported being subject to fully prospective rates (53.7%) or partially prospective rates (7.3%). Less than one-third (29.3%) received cost-based reimbursement for OPD services (see Exhibit VIII-2 in the previous chapter). For those with prospectively set rates, less than one-third (30.0%) received hospital-specific rates which included a trend factor for inflation. Over two-thirds of the hospitals with prospective rates indicated that their rates were based on arbitrarily set fee schedules (43.3%); historical-hospital specific costs that had not been adjusted for inflation (13.3%); or rates based on the mean, median or percentile of charges or costs to Medicaid (13.3%).

2. Payment Rates for Emergency Room Services

The ways in which states have chosen to pay for emergency room services are almost identical to those described above for OPD care. Where flat per visit rates were used, they ranged from $103 down to $25 per visit.

3. Payment Rates for Outpatient Surgery

Children's hospitals were more likely to receive per visit rates that varied by type of patient or visit for outpatient surgical care than for OPD or emergency room care (24.3% versus 11.4% and 10.3%, respectively) and correspondingly less likely to be paid according to charges. In this regard, Medicaid may be following Medicare's lead in moving to prospectively set rates for a small number of clusters of procedures and patients. Where a fixed payment per surgery was used, the rate varied from a high of $1192 to a low of only $23.[1]

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[1] Two of the eight hospitals reporting a single surgical visit rate had the same rates for OPD and outpatient surgery, including the low of $23.

The most frequently and emphatically stated problem with Medicaid outpatient payments was that Medicaid payment rates for outpatient services (of all types) are significantly below the cost of providing those services to Medicaid patients. The problem is especially pronounced for outpatient surgeries. Hospitals are taking greater advantage of improved technology and providing more ambulatory surgeries, which are often less traumatic, safer for the patient and less costly. The dilemma for the children's hospitals is in promoting greater use of ambulatory surgery in the face of the financial disincentives imposed by Medicaid payments which are well below cost.

4. Payment for Ancillary and Professional Services Provided to Outpatients

Ancillary services (laboratory, radiology, etc.) are usually, but not always, paid as separate items in addition to the visit payment. The majority of ancillary services are included in the visit rate for only 17.1 percent of the respondents. In 37.1 percent of the cases, ancillary services are paid under a fee schedule, while in 31.4 percent of the children's hospitals, they are reimbursed on a cost- or charge-related basis. Professional physician services were reported as included in the Medicaid payment rates for hospital OPD services by eight children's hospitals, while only five hospitals reported that the emergency room visit payment includes the professional component.

5. Cost and Volume Ceilings

Almost one-third of the children's hospitals (29.3%) reported Medicaid limits on the cost per visit or the volume of outpatient care they provide to Medicaid patients. However, this understates the hospital's ability to recover costs, since the majority of hospitals are subject to prospectively set rates which are often set arbitrarily or which fail to include a provision for cost inflation. In addition, as noted earlier, many states exclude or limit Medicaid outpatient benefits.

6. Disproportionate Share Payments

Only one state was reported to provide explicit outpatient disproportionate share payments. Federal law only requires such payments for inpatient care.

7. Impact of Inadequate Payment on Services and Access

Half of the hospitals responding to a question about outpatient losses reported that outpatient payment shortfalls are concentrated among certain categories of patients or have a bottom line impact on specific clinical services. Services frequently cited as having concentrated losses included:

- emergency room care
- mental health care
- physical therapy
- speech therapy
- dental care
- outpatient surgery
- oncology
- radiology
- transportation

The availability and access to outpatient services is in jeopardy of being curtailed because of inadequate Medicaid payments. Over one-quarter of the responding children's hospitals (26.3%) indicated that there were outpatient services which the hospital had postponed offering or had not expanded due to their potential for adding to Medicaid operating losses.

The ambulatory services which may be curtailed due to inadequate Medicaid payments included most of the services listed above. In addition, there was one hospital considering terminating emergency room services due to the large Medicaid patient losses that hospital is incurring and two other hospitals considering dropping all outpatient services for the same reason. These are clear and troubling examples of the impact substantial Medicaid losses can have on access to health care for all children.

8. Current Prospects for Changes in Medicaid Outpatient Reimbursement

Hospitals were asked to identify and assess the impact of Medicaid outpatient reimbursement changes likely to occur within the year. Most of the hospitals declined to make a prediction or thought there would be no change. Of the nine hospitals predicting changes, six expected major reductions in payment adequacy and only three expected some improvement. The predictions of reduced payments were primarily associated with shifts to prospective payments for outpatient services and state budget shortfalls.

C. Policy Options

There are several policy options to address outpatient payment adequacy, including:

- Expanding disproportionate share payments from inpatient services only to encompass the entire array of hospital-based services;
- Establishing a requirement that payments meet the costs of efficiently operated outpatient departments and emergency rooms (i.e., extending the existing inpatient requirement to encompass all hospital-based services); and
- Requiring HCFA to conduct a study on and set standards for payment adequacy relating to pediatric outpatient services.

There is some urgency to addressing the outpatient payment (and coverage) issues. As noted earlier, outpatient departments and emergency rooms are the primary source of care for a large segment of the Medicaid population. Until policies can be developed and implemented that actually expand Medicaid beneficiaries' access to physicians, the availability of hospital outpatient care will remain critical to the health of Medicaid children. Moreover, further cost-cutting via inadequate prospective rates for outpatient surgery will increase the disincentives for this mode of care. This could have a negative impact by actually increasing total Medicaid costs for surgical care and harm the health of children.

Chapter X

Promptness of Medicaid Payments

Introduction

This section examines problems faced by children's hospitals in obtaining timely payments for services provided to Medicaid patients. The key findings are that almost all children's hospitals have problems because of Medicaid payment delays and disputes. Over half of the hospitals had at least one quarter of a year's Medicaid billings tied up in accounts receivables.

A Medicaid requirement for interest on late payments, similar to that existing in the Medicare program, would help to alleviate the problem. Improvements in Medicaid eligibility processing, including HCFA approval of Medicaid Management Information Systems (MMIS) planning and development funds for enrollment systems enhancements to process new categories of Medicaid eligibles, would also help.

A. Overview of Issues:

Any time a major payor of health care services does not meet its responsibilities for making timely payments for services rendered, this creates an unfair and costly burden on hospitals. In those cases where the payor accounts for a major portion of the hospital's revenues, lack of payment and delayed payment can affect the hospital's financial stability. The less dramatic impacts are:

- o Increased operating costs because funds must be borrowed or diverted to provide working capital to meet payroll and supplier payments; and
- o Reduced access to long-term capital and higher interest rates.

The drop in the overall rating of hospital issued bonds in 1987 has been cited by many experts to be due to low profitability, low cash flow and overall poor financial indicators, including the statistic "days in accounts receivables."[1]

It is important for policymakers and the public to understand that the time value of money has a cost which affects both the costs of health care to society and the ability of health care institutions to cover their costs and pay their employees. It is also important to point out that costs Medicaid imposes on hospitals by being a slow payer are borne, in whole or in part, by other payors and are not included in our earlier analysis of Medicaid losses.[2]

B. Survey Findings:

Nearly all (85%) the 44 children's hospitals responding to this portion of the survey reported having a problem with promptness of Medicaid payments from their state's Medicaid program, as shown in

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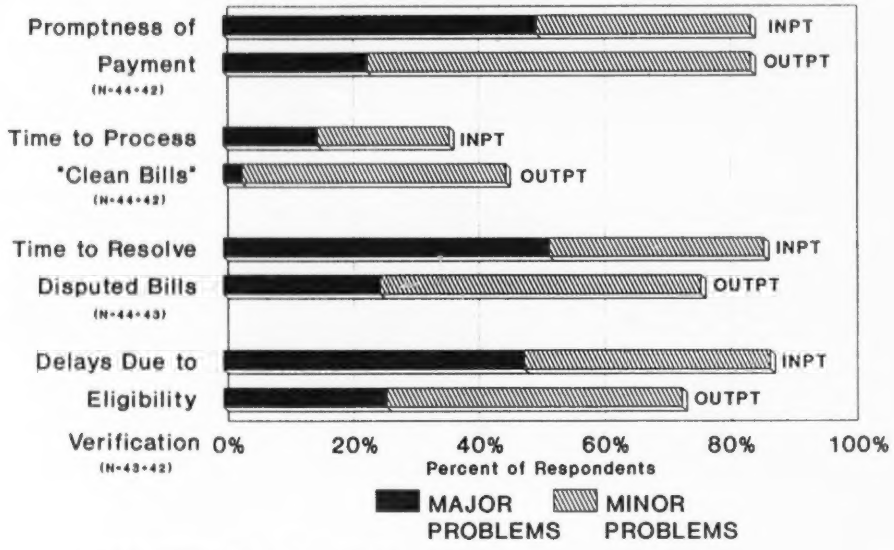
[1] "Medicare Prospective Payment and the American Health Care System: Report to the Congress," Prospective Payment Assessment Commission, Washington, D.C., June 1989, pp. 108-109.

[2] Medicare-Medicaid cost accounting principles disallow reimbursement for borrowing to meet working capital needs. Internal "borrowing" by not funding depreciation creates the need for more long-term capital debt financing, the costs of which are allocated to all payors.

Exhibit X - 1

Problems with Promptness of Medicaid Payment



Source: NACHRI Medicaid Reimbursement Survey, 1988.

Exhibit X-1. Major problems with promptness of inpatient payments affected half the hospitals (50.0%). Promptness of outpatient payments was reported as a major problem by 23.8 percent of the respondents. The components of the problems with lack of prompt payment are described below.

1. Days in Accounts Receivable:

The measure "gross days in accounts receivable" indicates how long on average a hospital has to wait to be paid after delivering services.[3] The number of days in accounts receivable for Medicaid accounts, shown in Exhibit X-2, supports the finding of major payment lag problems:

- Half of the hospitals (51.6%) have over 90 days in Medicaid gross accounts receivables.
- One-third (32.3%) have over 120 days in Medicaid accounts receivables. In other words, on any given day the amount of unpaid Medicaid charges equals one-third of all the charges for the Medicaid services provided in the entire year.

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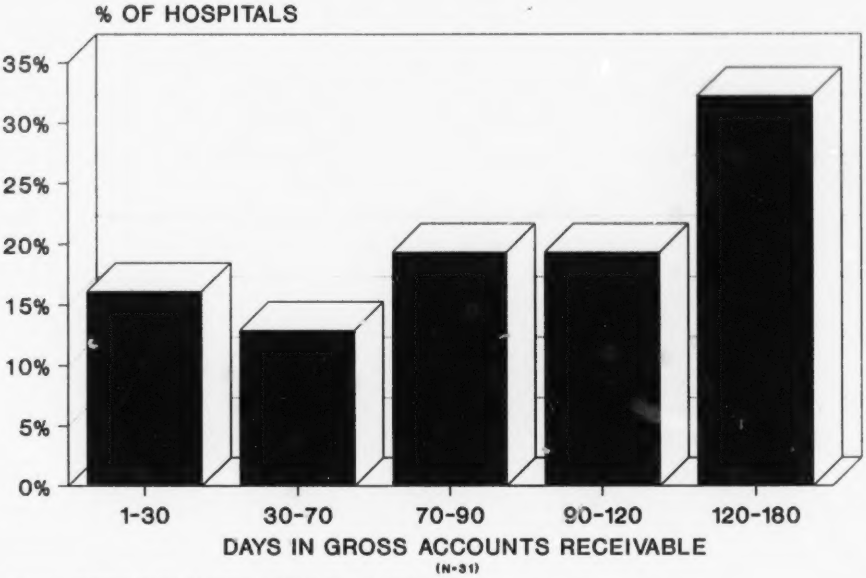
[3] Most hospitals include charges posted but not yet billed. Generally, charges are billed within 2-3 weeks of being incurred. Gross days in accounts receivables equals 365 times the average daily amount of charges in accounts receivables, divided by total annual gross revenue.

Exhibit X - 2

Medicaid Days in Gross Accounts Receivable



Source: NACHRI Medicaid Reimbursement Survey, 1988.

The accounts receivable problem is exacerbated by the absence of interim payments in some of the states which use DRGs or other payment at discharge policies. As noted in Chapter V, the small proportions of outlier and cases account for one-quarter to almost half of the revenues in children's hospitals and teaching general hospitals. These cases will generate a large amount of receivables in the absence of interim payments.

Another way to view the payment lag is in terms of the proportion of claims or billed charges which are unpaid after a reasonable amount of time from the date they were submitted for payment. One-quarter (23.6%) of the hospitals reported that more than 40 percent of dollar payments due on Medicaid claims had not been paid within 90 days of claims submission, while three-quarters (76.5%) had more than 20 percent of their payments delayed in excess of 90 days.

2. Processing of bills by Medicaid.

The major problems with payment delays are concentrated in:

- Resolving disputes over claims which were accurate and complete as submitted by the hospitals, but which were initially rejected as "unclean" by Medicaid fiscal agents.
- The time it took Medicaid to verify eligibility and issue an ID number, which resulted in delaying the issuance of claims by the hospitals.

About half of the hospitals had no problems with payment promptness on "clean" claims. Less than 20 percent had a major problem with clean claims. However the vast majority reported problems regarding the time to resolve "unclean" bills which were accurate and complete when submitted by hospital and delays in billing due to pending eligibility verification. These were major problems for about half the children's hospitals.

Respondents noted that their Medicaid programs had taken a variety of actions to save the state money by making the payment process very lengthy and complicated for the hospitals. For example, several hospitals complained about how difficult it was obtaining from the Medicaid program the form specifying the medically needy spend-down obligation, which the state requires the hospital to submit with the claim. Obtaining prior approval clearances for children who qualified for Medicaid only after being admitted was noted as a problem by several hospitals.

3. Non-payment due to lack of Medicaid program funds.

Suspension of Medicaid payments because the state ran out of Medicaid program funds appears to be a frequent and, for children's hospitals, difficult problem.

Nineteen hospitals in 16 states reported one or more instances in the past three years when their state's Medicaid program had run out of money and was unable to make payment for several weeks to as long as 12 weeks. For six of these hospitals it has happened in each of the last three years and for five others it has occurred twice in three years.

Payment suspensions can be very problematic for children's hospitals because of their duration and because a large portion of the hospitals' total revenue comes from Medicaid. The most recent payment suspensions lasted 12 weeks in three cases, and from six to nine weeks in four cases.

C. Policy Options

The major issue that must be addressed is the accountability of the state Medicaid programs to:

- Adequately fund the Medicaid program.
- Process eligibility applications and issue IDs promptly.
- Establish clear, consistent, and appropriate rules and procedures for claims submission.
- Process claims in a timely manner consistent with coverage and claims submission rules.
- Make timely payments to hospitals for services rendered, including interim payments.

One problem which many states may face is that their claims processing and MMIS have not kept up with the rapidly evolving changes in eligibility and benefits. An additional factor is HCFA's recent refusal to allow MMIS planning and development funds to be used to modify eligibility processing systems to handle the newly entitled non-welfare categories of pregnant women and children.[4]

One option which would reduce the costs of payment delays for hospitals and give Medicaid programs an incentive to improve their processing and procedures would be to set payment timeliness standards and require payment of interest on late payments, as now exists in legislation for Medicare. Policies which would speed up eligibility processing, such as presumptive eligibility, and enforcement of legislation allowing hospitals to bill for infants under the mother's ID would also help.

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[4] HCFA has argued that eligibility processing for these Medicaid-only eligibles should be accomplished through changes to the AFDC welfare eligibility systems.

Chapter XI

Out-of-State Care and Reimbursement

Introduction

This chapter addresses the special problems children's hospitals (and other referral center hospitals) face because, as specialized tertiary care providers, they often receive Medicaid patients referred from out-of-state. Two-thirds of the children's hospitals rated out-of-state Medicaid program payments as inadequate, while a majority also noted problems with obtaining prior approval to provide care and with obtaining prompt payments.

A. Overview on Issues:

Access to out-of-state care and reimbursement to children's hospitals by out-of-state Medicaid programs can pose problems because of prior approval and other requirements which are barriers to children accessing services and because some states use payment methodologies which discriminate against out-of-state hospitals. The problem is larger for some children's hospitals than others because of geographic location or because the hospital offers very specialized services found in few other hospitals. In addition, access may be limited due to benefit limitations imposed by states. Hospitals may also suffer large losses when they are not aware of such limits in advance of agreeing to provide care to an out-of-state child.

In a recently decided court case, the Commonwealth of Pennsylvania's Medicaid program was found to have discriminated against the West Virginia University Hospitals, Inc. because it had not paid out-of-state hospitals for disproportionate share, graduate medical education, and capital costs while it included these in payments to Pennsylvania hospitals.[1]

B. Survey Findings:

About half (52.4%) of the 21 hospitals who reported being affected by out-of-state Medicaid programs said that in general the inpatient payments they received for out-of-state Medicaid patients were worse than the payments they receive from their own in-state programs (see Exhibit XII-1). For providing treatment to out-of-state patients on an outpatient basis, eight of the 19 hospitals reporting (42.1%) said that out-of-state payments were worse than in-state payments. In no case did a hospital report better payment for out-of-state Medicaid patients.

Two-thirds of the hospitals responding (68.2%) rated the level of out-of-state payments as a major problem for inpatient care, while under half (42.1%) found outpatient payment rates to be a major problem. For all but one of the remaining hospitals out-of-state payment rate adequacy was indicated as a minor problem.

A majority of hospitals also noted problems with obtaining prior approvals and with promptness of payment, as shown in Exhibit XI-1.

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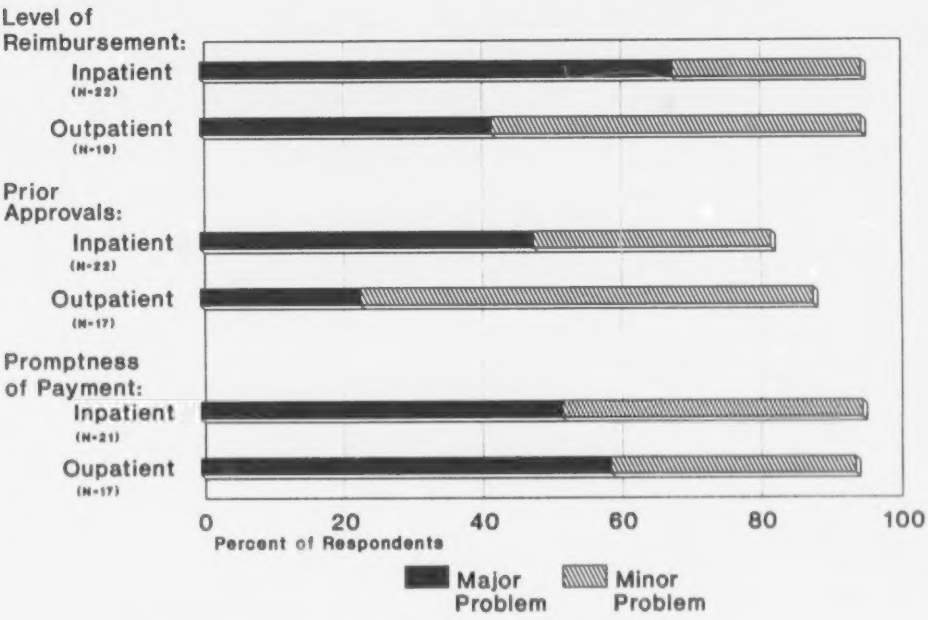
[1] West Virginia University Hospitals, Inc v. Robert Casey et al, Civil Action 86-0955, 1988.

Exhibit XI - 1

Problems with Out-of-State Medicaid



Source: NACHRI Medicaid Reimbursement Survey, 1988.

C. Policy Options:

Adequate payment for out-of-state care is clearly a necessity to assure adequate access. Hospitals often prefer to focus their resources for uncompensated care on patients coming from the hospital's basic service area. Also, with the exception of hospitals close to state borders, there are rarely provider agreements with other state Medicaid programs requiring the hospital to accept every patient desiring admission.

There are three basic alternatives for assuring adequate payments or eliminating discrimination in out-of-state care, but each poses some possible difficulties. The first alternative would be to require out-of-state Medicaid programs to reimburse at rates comparable to those they use for the hospitals in their own state. One problem here is that often the reason a Medicaid patient must go out-of-state is that the care needed is not available within the state. Thus, in many cases there would be no comparable in-state payment rate for the particular type of care being provided.

The second alternative would be to require out-of-state Medicaid programs to reimburse hospitals at the rate used by the hospital's own state Medicaid program. One problem is that some states would oppose having to follow payment rules set by another state. Another is that many of the prospective payment systems are very simplistic and pay a flat rate based on the average patient. Such rates would be inadequate and inappropriate for the very selective group of patients coming from out-of-state for very specialized care.

The third alternative would be cost- or charge-based reimbursement. While this would reasonably compensate for specialized care and would be relatively easy to administer, many states might be expected to view this as uncontrolled spending. However, this remains a good option in those cases where a flat rate prospective system is being used. Flexibility for the hospital and state to negotiate could be included for situations of high volume, as occurs for some hospitals close to a state border.

Chapter XII

Physician Reimbursement

Introduction

This chapter examines the issue of Medicaid physician payment adequacy. Children's hospitals perceive low Medicaid physician payments to represent a major problem for physicians and an access barrier for children seeking care in non-hospital settings.

A. Overview of Issues:

It is widely believed that children's access to care is threatened by the growing number of physicians who refuse to accept Medicaid patients because of the low level of reimbursement and problems in billing.[1] Public concern with prevention of premature births and assuring adequate prenatal care has focused attention on Medicaid participation by obstetricians.[2]

The most recent data on the level of physician participation in Medicaid by specialty are from 1977-78. Physician participation varies from a high of 90.3 percent for general surgery to lows of 64.4 percent for obstetricians and 57.8 percent for psychiatrists.[3] The percent of pediatricians accepting any Medicaid patients was 76.9 percent. However, these data may over-state the availability of physicians to Medicaid patients because many physicians in private practice limit the number of Medicaid patients they accept.[4]

One result of low physician participation in Medicaid is that Medicaid patients have difficulty locating physicians in the community and must often rely on hospital-based and attending physicians whom they access by seeking hospital outpatient or inpatient care. Medicaid patients make disproportionate use of outpatient departments for ambulatory care. Medicaid programs spent about $8 on outpatient care for every $10 spent on physician services, compared to Medicare which spent only $2.50 on outpatient services per $10 spent on physician care.[5] Medicaid patients being admitted to hospitals often have no regular physician and may be assigned to attending physician practicing at the hospital.

Due to the large proportion of Medicaid and uncompensated care patients in children's hospitals and other disproportionate share hospitals, the attending physicians on staff in these hospitals carry a larger burden of Medicaid patients than their private practice counterparts in other hospitals. As a result, the physicians practicing in children's hospitals often feel the strain of caring for a population that can not access care through other means. Children's hospitals may bear the financial burden in those cases where the hospital employs staff physicians.

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[1] "Medicaid Source Book," p. 441.

[2] For example, the OBRA 1987 disproportionate share provisions require general hospitals to have on staff at least two obstetricians who accept Medicaid in order to qualify for disproportionate share payments. Other legislative remedies addressing obstetric access have also been proposed.

[3] Janet B. Mitchell and Rachel Schurman, "Access to Obstetrics/Gynecology Under Medicaid," Medical Care, Vol. 22, No. 11 (November 1984), p. 1028, as cited in "Medicaid Source Book," p. 446.

[4] For example, they may not accept new Medicaid patients while continuing to accept established patients who have become Medicaid eligible through loss of employment.

[5] "Medicaid Source Book," p. 444.

A special problem faced by certain specialists within children's hospitals is procedure coding systems and fee schedules which do not recognize the special complexities of care for neonates and young children. Surgical procedures and anesthesiology are particularly affected by neonates' small size and lack of physiological reserves. For example, a premature baby weighing 600 grams (1.3 lbs.) is about as small as a toy doll. The fee paid for surgery or anesthesia for this infant is often the same as is paid for the same type of procedure on an adult or older child.

National data from HCFA indicate that, in general, Medicaid physician payments are considerably lower than those allowed under Medicare. The adequacy of Medicaid payment levels for physicians varies widely from state-to-state and by type of service. As of 1986, state maximum Medicaid payments for a brief follow-up office visit equaled only 67 percent of the Medicare maximum allowable charges, on average. In 12 states, the payment was less than $10, with New Hampshire paying only $6.00. Payments by Medicaid for an appendectomy averaged 60.6 percent of the Medicare rate. New York Medicaid paid only $160, which compares to the $1140.20 allowed by Medicare.[6]

B. Survey Findings

Our survey of children's hospitals asked the hospitals for their perceptions regarding the impact of low Medicaid payments on physicians. However, the survey did not ask how children's hospitals were financially affected by the physician payment problems, except as regarding recruitment and subsidies provided to physicians.

The responding children's hospitals were virtually unanimous in reporting their perception that Medicaid fee levels posed a serious or significant problem for various types of pediatric physicians, as shown in Exhibit XII-1.[7] A majority thought that pediatric specialists practicing in children's hospitals had very serious problems with Medicaid physician payment amounts. Half of the hospitals thought that pediatric physicians had very serious or significant problems with promptness of payment from Medicaid and, to a lesser extent, with billing procedures.

Almost all of the hospitals indicated that they believed these payment problems resulted in serious problems for children in accessing non-hospital based ambulatory care. Over half indicated that the problems were very serious or significant and affected rural and suburban children, as well as those living in urban inner city areas.

High Medicaid loads in children's hospitals coupled with low Medicaid payments could result in physician recruitment problems. Just over half the hospitals (53.3%) indicated that they require all attending physicians to accept Medicaid. Although slightly over one-third of the children's hospitals (37.9%) reported low Medicaid fees as a recruitment problem, most said the recruitment problems were minor.

However, 56.7 percent found it necessary to supplement the income of their practice plan academic physicians to compensate for low Medicaid payments, often by offering reduced rate or free office space and support staff. A minority of the hospitals (21.4%) compensate private practice attending physicians

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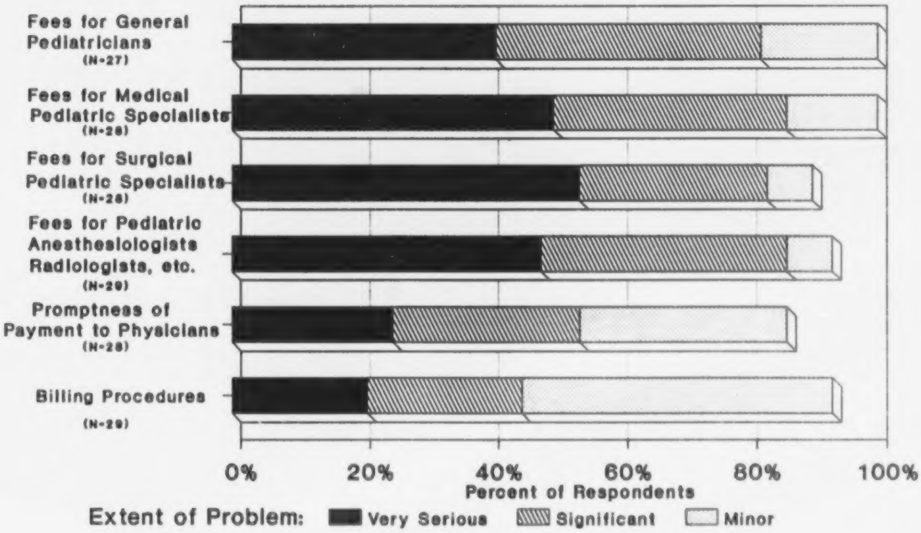
[6] "Medicaid Source Book," pp. 450-452.

[7] Only 30 of the 50 survey respondents (60.0%) completed one or more questions about physician payments.

Exhibit XII - 1

Medicaid Physician Payment Problems as Cited by Hospitals



Source: NACHRI Medicaid Reimbursement Survey, 1988.

for low Medicaid payments. Thus, children's hospitals may also incur uncompensated costs in their service to Medicaid children which are not reflected in the financial analysis.

C. Policy Options:

There is no simple answer to the problems of Medicaid patient access and payments to physicians. Short of setting a national payment standard putting Medicaid payments on a par with Medicare (for example), fruitful approaches to increasing obstetric and pediatric physician participation could include:

- Setting special Medicaid payment schedules or supplements for physicians with a disproportionate share of Medicaid patients or for those who practice in areas where there is a shortage of physicians taking Medicaid. Either of these approaches risks encouraging or rewarding "Medicaid mills." In order to assure quality of care, disproportionate share payments to physicians could be tied to a requirement for a staff appointment in a disproportionate share hospital. This would hold down the cost of increased payments and focus them where the impact of low payment is greatest.

- Addressing the bureaucratic impediments which deter physician participation by encouraging states to work with established physician organizations in problem identification and resolution. PROs and other review mechanisms can identify access problems by backtracking instances where children are admitted to hospitals with conditions reflecting inadequate access to quality ambulatory care.

Chapter XIII

Recommendations for Medicaid Reform and Improvements

This chapter provides NACHRI's recommendations for reforming and improving the Medicaid program and its ability to meet the needs of poor and inadequately resourced children. The recommendations are intended to be comprehensive in scope. However, many of the proposed program enhancements are suitable for phased-in implementation.

The first section discusses the key Medicaid components needed to achieve the program's objectives for children, including access to care, ensuring the appropriateness and quality of care, and the commitment of adequate resources. The second section presents NACHRI's specific proposals for reforming and improving Medicaid eligibility, enrollment, service, coverage, and access for children. The final section presents a general estimate of the cost of the NACHRI proposals.

A. Medicaid Program Objectives for Children

The ultimate goal for Medicaid and other public and private programs for children is to ensure that children have both the opportunity and encouragement to grow and develop to their fullest potential; to attain adulthood as independent, functioning, cognitive persons who are capable and motivated to participate fully in the economic, intellectual, and spiritual advancement of our society and in their own family lives.

There are three key objectives for Medicaid to achieve in meeting the health needs of children and fostering their development towards becoming productive adults:

- Achieve access to health care services for poor and inadequately resourced children equal to that of other children;
- Ensure that beneficiaries receive quality services in appropriate settings; and
- Secure the commitment of adequate resources to support the efficient delivery of these services.

Meeting these goals and objectives benefits everyone; they should serve as the foundation for a national children's health policy which is currently lacking. All of society benefits when children grow to become healthy, productive adults. There are considerable savings to society in maintaining and educating healthy children. It is also in the self-interest of the current generation of working adults to support health and education for the current generation of children. The future contributions of today's children to personal earnings and the economic health of this Nation will determine whether there will be adequate health benefits and income support benefits from the Social Security system when today's generation of adults retire.

1. Achieving Equal Access

A national health policy is needed to assure that children who lack health insurance or have inadequate insurance have no less opportunity for a healthy future than other children. There are three populations of children who need the assistance of Medicaid in order to have equal access to care.[1] These are:

- Poor and near poor children who lack health insurance or cannot afford the deductibles and co-insurance payments;
- Children with catastrophic illnesses where the uninsured expenses threaten to exhaust family resources; and
- Children with chronic or disabling illnesses where the ongoing uninsured expenses of care can be expected to substantially undermine the family's economic productivity or security or excessively deplete the family's disposable income.

Medicaid is and will likely continue to be the financing source of last resort. However, now it only partially fills the gaps in private financing. The program should have as its goal completely filling the gap in financing so that there will be equal access to health care for all children.

One way to close the gap is to improve the scope and effectiveness of the private system of health insurance, which is the mainstay of health care financing and access in the United States. This could be accomplished through economic development and growth of new jobs and/or by ensuring that the benefits of employment-based health insurance are provided to all working Americans and their families. However, there will always be some children who will require health care financing from another source because of parental unemployment, poverty, abandonment or health needs beyond the scope of some private coverage. It is these gaps in private coverage which Medicaid should fill.

It should be understood that Medicaid can fill these gaps in health care financing completely only under a system which assures -- through mandates and incentives -- that the present level of employment-based health financing is maintained or improved. Currently, the Congress is considering a variety of different approaches, including mandated minimum employer-paid health benefits for dependents as well as employees; tax penalties for employers that fail to provide coverage for employees and their families; and, tax credits to encourage individuals to purchase private family coverage.

Without such provisions built into health care coverage reform for low income families, some employers would gain an unfair competitive advantage by reducing or eliminating health insurance benefits and dumping their employees and their children onto Medicaid. In other words, filling the gap means limiting the size of the gap in the first place. Medicaid reform should build on the principle that

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[1] Although the term equal access is used, equitable access might more accurately convey the intended policy for three reasons. First, there are some health services which society may deem too frivolous to be worth assuring equal access to them. Cosmetic surgery to enhance an already acceptable or normal appearance is one example. Second, there are some individuals whose needs go beyond the services which are typically covered by private insurance, but where it is in society's interest to provide care because of benefits to the patient or society or simply out of compassion. These may include rehabilitation of accident victims, habilitation of the developmentally disabled, and non-medical supportive services for the severely disabled and terminally ill. Third, geographic considerations would make it difficult to ensure the same proximity of access for all.

Medicaid is the payer of last resort and that Medicaid reform should be accompanied by private sector reforms.

Assuring access means more than defining the population to be served. It also means getting the services to that population by putting Medicaid cards in the hands of the eligibles and making sure those cards open the same doors to care as does private insurance. Attaining this objective is a task that will require the involvement of Medicaid programs and health care providers, as well as social service agencies, schools, churches, and other institutions.

2. Ensuring Quality and Appropriateness

Medicaid should support access to high quality health services. Quality includes effectiveness in preventing and treating illness and disability, as well as services which meet the patient's and family's expectations for courtesy, timeliness, and involvement in decision-making and the care process. For children, quality also means receiving health care in a supportive, non-threatening environment, in concert with other services and interactions which are essential to the development of the child, such as nourishment, play, education, acceptance, and love.

Adequate and appropriate payment levels, elimination of benefit limitations and exclusions, and meaningful quality assurance mechanisms are needed to insure that quality is provided. In the long run, quality care is less expensive because it is more effective.

The best way of assuring quality is a one-tier system of care, serving Medicaid children in the same settings as those which serve more affluent members of society. Medicaid policies should encourage broad provider participation.

Children thrive and grow best in the home environment. Thus, quality and appropriateness for the health care of children is best considered in terms of how easily children may access the services they need without being hospitalized. Payment policies should provide incentives for outpatient care and for preventive services.

3. Commitment of Adequate Resources

Medicaid can only accomplish the first two objectives of assuring access and quality if the program receives adequate resources, both in funds for the purchase of health care services and in administrative funds. If the program is to accomplish its goals, which clearly require an expansion of both the beneficiary population and the service benefits, as well as improved payments to providers and practitioners, there must be a commitment to provide adequate resources.

Throughout the 1980s, most Medicaid programs have been operating in a constrained fiscal environment and few Medicaid programs have had adequate resources. Eligibility levels which declined in the first half of the decade have improved in the second half, but many Medicaid programs have not restored cutbacks on service benefits and on reimbursement levels implemented as part of cost-containment in the early 1980s. Unfortunately, the cutbacks have been concentrated in the services used by children. As a result, Medicaid per capita spending on the care of children, measured in constant health purchasing dollars, actually declined by 14.4 percent from 1978 to 1984, as discussed in Chapter IV, while spending for other Medicaid groups increased or held steady.

There is a renewed concern that resources for the care of children will again be cut. In 1988, the Congress mandated expansions in Medicaid eligibility for infants, pregnant women, and the elderly with incomes below the federal poverty level. The Congress also acknowledged that in assuring expanded access to care for infants, that adequate payment and adequate service benefits go hand-in-hand with eligibility.

Many states are now trying to figure out how to finance these expansions. There is much concern that "savings" will be extracted from provider payments to fund expanded access. However, further cuts in payments may well have the effect of curtailing access, particularly for children and AFDC adults.

There needs to be a commitment of additional resources just to maintain the current level of services and payments as states implement recently enacted expansions. After a decade of heavy emphasis on cost containment in Medicaid, there are probably few additional opportunities for improving efficiency without further jeopardizing access. Further, there need to be additional resources if Medicaid is to improve access for pregnant women and children.

Enhanced federal matching rates could be used to ease the burden on those states which shoulder the largest increases in implementing mandated and other improvements in eligibility, benefits, and access. The higher matching rates would need to be tied to maintenance of effort requirements to avoid reprogramming existing funds into new efforts at the expense of current commitments.

The section which follows details our proposals for accomplishing these goals and objectives for children.

B. Specific Proposals for Reform and Improvement of Medicaid Eligibility, Enrollment, Service Coverage, and Access for Children

The body of this report has detailed many problems with the Medicaid program as it currently serves children. It has also discussed various policies and alternatives to ameliorate or eliminate these problems. As noted earlier, NACHRI believes that effective Medicaid reform ultimately depends on a system of incentives and/or mandates that will maximize the continuation and even expansion of private coverage. At the same time, Medicaid reform must be designed to complement efforts to strengthen private coverage. At a minimum, this requires a continuation of federal policy that Medicaid must always be the payer of last resort. It also should include provisions, such as the "work transition" requirements of the 1988 welfare reform legislation, which permit Medicaid to buy into private, employer-paid coverage for employed Medicaid eligibles, where appropriate. Such "buy-ins" should provide not only Medicaid payment of the employee's share of the premium, but also Medicaid wrap-around coverage to pay for items such as deductibles and essential services which are not always covered in private insurance (eg., basic dental care for children).

1. Establish More Uniform and Equitable Medicaid Eligibility Standards for Children Under the Age of 18 and Facilitate Enrollment

Eligibility for Medicaid should be de-linked from welfare and national standards should be established. Medically needy assistance should be nationwide and should prevent, not result in, medical indigence. The specific components for children are:

a. Set the eligibility standard at 185% of the federal poverty level for all children and pregnant women. (This would expand the existing optional coverage for pregnant women and infants to encompass all children and would make it mandatory.)

Allow states several options to facilitate expanded eligibility:

- Permit states to use a higher income standard than 185 percent of poverty.

- Permit states to charge premiums or nominal copayments, not to exceed a set percent of family income, for those with incomes over 150 percent of the federal poverty standard.

- Permit states to purchase employer-offered health insurance for working poor eligibles (including payment of premiums, as well as provision of wrap-around coverage). This provision is particularly important to complement any tax credit incentive for health care insurance, such as that proposed by Senator Bentsen in 1989.

b. Mandate medically needy programs in all states and put a sliding dollar cap on the spend-down requirements so that families would be able to retain a reasonable percentage of income and assets. Also, set the medically needy eligibility level at least as high as the mandatory eligibility level for children to avoid a "notch" effect where the spend-down reduces income below the level needed to qualify as a regular Medicaid eligible.

Permit states to eliminate the spend-down and instead collect premiums and impose fixed nominal copayments, thus avoiding both the access problems which face the beneficiaries and the problems providers now have in learning from Medicaid how much the patient is supposed to pay.

c. Eliminate or liberalize asset tests. Eliminating the asset tests would considerably simplify the application length and complexity, as well as reduce application processing costs. The asset test should be dropped for those with incomes below 100 or 150 percent of poverty and set no more stringent than the SSI asset standard for others.

Provide for retroactive spend-down of "excess" assets on the same basis as spend-down of "excess" income. This would eliminate the existing requirement that assets must actually be disposed of before eligibility can be established, even when there are large outstanding medical bills.

d. Mandate the special eligibility provisions (which are now an option under Section 134 of TEFRA) to allow some or all categories of technology dependent and disabled children to continue their Medicaid eligibility when it is appropriate and less costly for them to leave hospitals and other institutions.[2]

When the medically needy program is reformed, allow a higher income standard and/or lower spend-down requirement for technology dependent and chronically ill children. (This would take into account the non-monetary and non-medical costs families incur in caring for these children at home and in transporting them to medical services.)

e. Facilitate immediate access to care through presumptive eligibility and streamlined eligibility processing. Allow qualified health providers, social service agencies, and community organizations to take applications on-site.

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[2] Note: this proposed provision would only ensure Medicaid eligibility. Complementary service coverage expansions are also needed because meeting the special care needs of these populations in home and community settings often requires services which are not presently covered or reimbursed in many states.

B2. Establish Greater Uniformity and Appropriateness in Service Packages

a. Establish improved minimum benefits for all children by eliminating the option to exclude mandatory services for the medically needy and by adding the following services (most of which are already provided to children in most states) to those which are already mandatory:

- inpatient and outpatient rehabilitation
- dental services
- prescribed drugs
- eyeglasses
- preventive services
- medical transportation
- skilled nursing facility care
- hospice services

b. Require or permit states to offer an enhanced package of services to meet the special needs of technology dependent and chronically ill/disabled children. Such expansions should be coordinated with the Title V MCH block grant funding for children with special needs and with the provision of educationally-related health services as required under Parts B and H of the Education of the Handicapped Act.

- For technology dependent children: Allow or require all states to provide all medical, personal care, and other services required by technology dependent children living at home or in the community, without the necessity of obtaining a Section 2176 Home and Community-based Care waiver. To ensure that states implement adequate service coverage for technology dependent children, require states to demonstrate that not more than a set percent of technology dependent children for whom home care is medically appropriate are institutionalized.

- For chronically ill and disabled children: Permit or require states to provide a broader and deeper benefit package of services meeting the special needs of children with particular chronic or disabling conditions. Examples include: physical therapy, speech therapy, and prosthetic devices for physically disabled children and habilitation services for developmentally disabled children.

c. Phase-out of limits on essential services such as inpatient care, physician and outpatient visits, and prescription drugs. Implementation of the phase-out should begin with disproportionate share providers. Ultimately, states should be required to eliminate limits on all services (other than limits related to medical necessity and appropriateness criteria). Since the Medicaid program serves people who either have little income or have exhausted their resources on health care, it is inappropriate to expect they will be able to purchase additional services over the limits when they are needed. The alternatives are that the child goes without, or the provider assumes their financing.

B3. Assure Access and Efficiency through Adequate and Appropriate Reimbursement Methods and Rates

a. Specific standards of payment adequacy should be established to implement the 1981 law requirement that inpatient payments meet the costs of efficiently and economically operated hospitals. These standards should specifically address the financial requirements of disproportionate share hospitals. HCFA should be required to: (1) review state plans and operations with respect to these standards; (2) enforce the standards through Congressionally established sanctions for non-compliance; and (3) periodically report to the Congress on the adequacy of Medicaid payments to hospitals.

b. Payment methods should provide appropriate incentives for efficiency. Payment levels based on the needs of average patients in average facilities create access problems for those children with complex and special needs.

Payment methods and rates need to recognize differences in the patient mix and care provided by specialized pediatric providers.

Payment rates for outpatient surgery and other outpatient services should be set at a level relative to inpatient rates, so that providers have incentives to provide less expensive care in the outpatient setting.

Health care providers should join with HCFA and Medicaid programs in investing and participating in independent research and development of clinically-oriented, severity-sensitive, improved case mix measurements that reflect differences in the resources used in the health care of children more accurately than the present generation of Diagnosis Related Groups (DRGs) and severity indexes.

c. Congress should require HCFA to report on the effectiveness and timeliness of states' implementation of the Medicare Catastrophic Coverage Act provisions regarding adequate payment for exceptionally long and costly stays in disproportionate share hospitals.

d. Congress should require HCFA to report annually on the states' implementation of the inpatient disproportionate share payment adjustments.

e. Disproportionate share payment adjustments should also apply to hospital outpatient care. The disproportionate share payment adjustments should be commensurate with the discrepancy between the basic Medicaid payment levels and the financial requirements of the disproportionate share hospitals in delivering care to Medicaid and other uncompensated care patients.

f. Medicaid payments to out-of-state hospitals should be comparable to the payments these hospitals receive from their own state's Medicaid program and should reflect the special patient needs which generate inter-state referrals.

g. Prompt payment should be encouraged by a requirement for payment of market-rate interest on clean claims which have not been paid within 25 - 30 days (as Medicare does) and on claims which have been erroneously been rejected. Alternatively, disproportionate share hospitals should receive periodic interim payments.

h. Access to high quality physicians' services should be improved through:

- o requirements that states set fees for obstetricians, pediatricians, pediatric specialists, and other providers of pediatric care that are adequate to assure Medicaid beneficiaries have access on the same basis as insured children.
- o more effective monitoring and enforcement of existing prompt payment requirements for physician services; and
- o implementation of disproportionate share payments for pediatric and obstetric care physicians.

i. As Medicaid programs seek to improve program efficiency and access to care for enrollees without a regular source of care through managed care programs, they must provide basic safeguards:

- o Freedom to choose between an individual provider and a managed care system(s) is the most basic safeguard for access and quality.
- o Children with special care needs must be permitted to access an appropriate specialist as the care manager.
- o Access to emergency and urgent care should be assured through adequately monitored on-call requirements for care managers and through payment of a fee for the triage or assessment the emergency room is legally required to perform when a managed care enrollee seeks such care without or prior to care manager authorization. Care managers should be responsible for educating enrollees in appropriate use. They should also be held accountable for inappropriate care seeking behavior; for example, capitation payments could be reduced if unauthorized use exceeds a set level.
- o Managed care systems must demonstrate they have established arrangements and incentives for delivery of appropriate specialized inpatient and outpatient services.
- o States must require bonding and/or make other provisions in advance, including payment guarantees to providers, to ensure beneficiary access to care is not jeopardized in the event of bankruptcy of a managed care plan.
- o The effectiveness and impact of managed care on beneficiary access and outcomes should be assessed through both independent evaluations and ongoing monitoring by states and HCFA.

B4. Commitment to Adequate Resources

a. Maintenance of Effort

Maintenance of effort is a basic requirement to assure continuing and improving access to care as Medicaid reforms are implemented. Expansions in Medicaid eligibility and services without commensurate program funding increases will have serious negative impacts not only on the Medicaid beneficiaries, but also on the other citizens who are served by those institutions and providers which have committed themselves to serving all segments of the public.

States which inadequately fund their Medicaid programs ultimately impose additional economic costs on themselves and their citizens. There are costs to Medicaid and to other payors when hospitals faced with Medicaid payment interruptions must borrow money to meet payroll and pay suppliers. Lack of predictable and adequate payment undermines public confidence in government and is likely to add to the access to care problems which poor children face.

The federal government has an equal responsibility with state governments to assure that adequate resources are committed to entitlement programs. Neither the federal government nor the states should cut services or payment levels in order to finance eligibility expansions. Nor should they meet new requirements for adequate benefits by cutting reimbursement rates. Since the costs of meeting the eligibility and benefit improvements which this proposal would require fall unevenly across the states, it would be most appropriate for those states with largest required increases to receive enhanced federal matching funds. Enhanced federal funding would be tied to maintenance of effort requirements.

One way to help avoid a repeat of the reduced Medicaid spending on children, which occurred between 1978 and 1984, is to require states and HCFA to prepare Medicaid budgets which explicitly show the impact of policy proposals and budget decisions on spending for children's health care.

The responsibility for maintenance of effort and budgeting for children should be incorporated into HCFA's review and approval of the annual state submissions of budget projections and state plans for reimbursement. HCFA should report its analysis and findings to the Congress.

b. Voluntary Contributions

On several occasions in recent years, major gaps in the availability of state funds for the Medicaid program have threatened to undermine access to care. In several states, hospitals voluntarily stepped forward and donated funds to their Medicaid programs. These funds allowed the states to obtain federal matching funds, which in turn kept their Medicaid programs intact. In Tennessee, for example, voluntary contributions by hospitals enabled the state to introduce program enhancements for pregnant women and children and to fund disproportionate share adjustments.

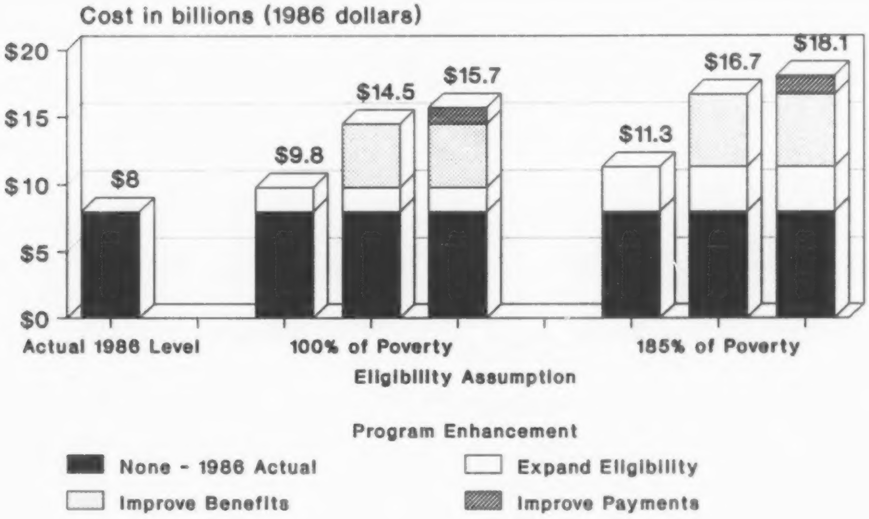
During the past year, HCFA and OMB have indicated a desire to prohibit voluntary contributions to Medicaid. Even though reliance on voluntary contributions is not the most appropriate mechanism for long-term funding of an entitlement program, the Congress should codify regulations as they existed in 1988 to provide specific legal authority so that voluntary contributions can remain an option for continuing to maintain access in times of state fiscal distress.

C. Costs

How much of an investment in children will be required to implement these proposals? General estimates are provided below for the major proposals: expanding eligibility to 100 percent or 185 percent of the federal poverty line; establishing a standard benefit package for children without limits on medically necessary services; and improving provider payments. Others cannot be estimated at this time. Notably, it is not possible to estimate the cost of expanding the medically needy program and limiting the spend-down obligation an a way that would fill the gap left by private health insurance without knowing whether and what type of employer mandates or subsidies for health insurance may be enacted on the state or national levels. No figures are given for covering children above 185 percent of the poverty line. Although the cost of eliminating or liberalizing asset tests for children was not specifically estimated, the small proportion of Medicaid and AFDC applications rejected for excess assets suggests that the cost would be quite low, particularly in comparison to the cost of eliminating the asset test for the elderly.

Exhibit XIII - 1

Medicaid Improvements for Children: Estimated Total Federal and State Costs



Note: see text for details.

Expanding Medicaid to all children below 100 percent of the federal poverty line would add about $1.8 billion (in 1986 dollars) to the $8 billion the federal and state governments spent on Medicaid for children in 1986 (as shown in Exhibit XIII-1).[3] Expansion to 185 percent of the poverty line would bring the total added cost to about $3.25 billion (in 1986 dollars), according to NACHRI estimates. Although current health care costs are higher than in 1986, the number of uninsured children are probably declining measurably due to ongoing implementation of optional and mandatory expansions in Medicaid eligibility for children enacted by the Congress in 1986, 1987, and 1988. Expansion to 185 percent of poverty would cut the number of uninsured children in the U.S. (in 1986) from 12 million to 4.5 million.[4] The costs of improving medically needy eligibility for insured children and for uninsured children above 185 percent are not included in this estimate.

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[3] Medicaid expenditures per child using services (for AFDC, non-cash, and medically needy children) averaged $582 in fiscal year 1986. (Source: HCFA 2082 data in "Medicaid Source Book," pages 49 and 238-241.) Per enrollee expenditures are estimated to be $433, based on an estimated 74.4 percent of enrollees using services. (Source: David K. Baugh, Embry M. Howell, and Penelope L. Pine, "Patterns of Medicaid Utilization and Expenditures in Selected States 1980-1984," Health Care Financing Review, Vol. 10, No. 2 (winter 1988) p 7.) This figure may over-estimate the added cost because a large proportion of the new eligibles are likely to be added in states with below average per capita Medicaid spending for children.

There were 4.223 million uninsured children below 100 percent of poverty and another estimated 3.284 million uninsured children between 100 and 185 percent of poverty (85 percent of the 3.863 million uninsured children between 100 and 200 percent of poverty) in 1986. (Source: Current Population Survey data in "Medicaid Source Book," pages 305 and 333.)

Standardizing benefits at a "high" level in all states for current Medicaid beneficiaries under age 65 was estimated to increase costs by 48.2 percent.[5] At this rate of increase, improved benefits for children (including new eligibles up to 185 percent of poverty) would add about $5.42 billion to Medicaid costs (in 1986 dollars). This estimate is probably on the high side because some of the services which states exclude from the general Medicaid program, such as dental care and eyeglasses, are currently available to children under the EPSDT benefit.

Improving provider payments was estimated as increasing costs by 8.27 percent.[6] At this rate, the added costs (in addition to expanding eligibility for children to 185 percent of poverty and improving their benefit packages) would be $1.38 billion.

The total costs to the federal and state governments of the main components of the NACHRI proposal are about $10 billion (excluding the medically needy component, expansion to include technology dependent and chronically ill children above 185 percent of poverty, and inflation). It should be noted that the costs to society of these expansions are less than the costs to government because of offsets to existing uncompensated care costs and out-of-pocket spending for health care. It is quite possible that the net additional cost would be only about one-third or less of the direct cost to governments.[7] Also, any private or government actions to expand private insurance would reduce the numbers of children on Medicaid. Thus, net of existing uncompensated care costs and out-of-pocket expenditures, the added cost to the nation would be in the vicinity of $3 billion (in 1986 dollars).

This increment in health care expenditures would assure adequate health care for some 7.5 million children who, as of 1986, had limited or no access to care because they were without insurance or Medicaid. It would also benefit the approximately 10 million children who already had Medicaid (as of 1986) because it would improve their benefits and expand the pool of providers serving the Medicaid population.

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[4] Based on the previously cited 1986 CPS data.

[5] The estimate assumed that all states would adopt the benefit package provided by Minnesota. Source: Kenneth E. Thorpe, Joanna E. Siegel, and Theresa Dailey, "Including the Poor: The Fiscal Impacts of Medicaid Expansion," JAMA, Vol. 261, No. 7 (February 17, 1989), p. 1003-1007.

[6] Ibid.

[7] Ibid.

APPENDIX

APPENDIX

Status of Children's Hospitals
Included in NACHRI Medicaid Reimbursement Survey

Name of Children's Hospital	City	State	Type	Responded to Survey	Included in Finance Analysis
The Children's Hospital of Alabama	Birmingham	AL	free	X	X
Arkansas Children's Hospital	Little Rock	AR	free	X	X
Children's Health Center, St. Joseph's Hospital	Phoenix	AZ	joint		
Phoenix Children's Hospital	Phoenix	AZ	free		
University Medical Center Children's Hospital University Medical Center	Tucson	AZ	joint		
Valley Children's Hospital	Fresno	CA	free	X	X
Miller Children's Hospital	Long Beach	CA	joint		
Children's Hospital of Los Angeles	Los Angeles	CA	free		
Children's Hospital Medical Center of Northern California	Oakland	CA	free	X	X
Children's Hospital of Orange County	Orange County	CA	free		
Children's Hospital at Stanford	Palo Alto	CA	free	X	
Children's Hospital and Health Center	San Diego	CA	free		
The Children's Hospital	Denver	CO	free	X	X
Newington Children's Hospital	Newington	CT	free	X	X
Children's Hospital National Medical Center	Washington	DC	free	X	X
The Hospital for Sick Children	Washington	DC	spec	X	X
Jacksonville Wolfson Children's Hospital at Baptist Medical Center	Jacksonville	FL	joint		
Miami Children's Hospital	Miami	FL	free	X	X
Children's Hospital at Sacred Heart	Pensacola	FL	joint		
All Children's Hospital, Inc.	St. Petersburg	FL	free	X	X
The Henrietta Egleston Hospital for Children	Atlanta	GA	free	X	X
Scottish Rite Children's Hospital	Atlanta	GA	free	X	X
Children's Medical Center Medical College of Georgia Hospital and Clinics	Augusta	GA	joint		
The Children's Memorial Hospital	Chicago	IL	free	X	X
La Rabida Children's Hospital and Research Center	Chicago	IL	spec		

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Status of Children's Hospitals
Included in NACHRI Medicaid Reimbursement Survey

Name of Children's Hospital	City	State	Type	Responded to Survey	Included in Finance Analysis
James Whitcomb Riley Hospital for Children	Indianapolis	IN	joint		
Kosair Children's Hospital	Louisville	KY	joint	X	
Children's Hospital	New Orleans	LA	free	X	
The Children's Hospital	Boston	MA	free	X	X
Franciscan Children's Hospital and Rehabilitation Center	Boston	MA	spec	X	X
Floating Hospital for Infants and Children, New England Medical Center	Boston	MA	joint	X	
The Kennedy Institute	Baltimore	MD	spec	X	X
Mt. Washington Pediatric Hospital, Inc.	Baltimore	MD	spec		
C.S. Mott Children's, University of Michigan Hospitals	Ann Arbor	MI	joint	X	
Children's Hospital of Michigan	Detroit	MI	free	X	X
Lutheran General Hospital	Park Ridge	MI	joint	X	
Minneapolis Children's Medical Center	Minneapolis	MN	free	X	X
Variety Club Children's Hospital at the University of Minnesota Hospital and Clinic	Minneapolis	MN	joint		
Gillette Children's Hospital	St. Paul	MN	spec		
The Children's Hospital	St. Paul	MN	free		
The Children's Mercy Hospital	Kansas City	MO	free	X	
Cardinal Glennon Children's Hospital	St. Louis	MO	free	X	X
St. Louis Children's Hospital	St. Louis	MO	free	X	X
Children's Hospital at the North Carolina Memorial Hospital	Chapel Hill	NC	joint		
The Children's Medical and Surgical Center of Duke University Hospital	Durham	NC	joint		
Children's Hospital -- Merit Care	Fargo	ND	joint	X	
Children's Memorial Hospital	Omaha	NE	free	X	X
Boys Town National Institute for Communication Disorders in Children	Omaha	NE	spec		
Pediatrics Department, University of Nebraska Medical Center	Omaha	NE	joint		
Children's Seashore House	Atlantic City	NJ	spec		

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Name of Children's Hospital	City	State	Type	Responded to Survey	Included in Finance Analysis
Children's Specialized Hospital	Mountainside	NJ	spec	X	
Children's Hospital of New Jersey/United Hospitals Medical Center	Newark	NJ	joint		
Carrie Tingley Hospital for Crippled Children	Albuquerque	NM	spec		
St. Mary's Hospital for Children	Bayside	NY	spec		
The Children's Hospital of Buffalo	Buffalo	NY	free	X	X
Schneider Children's Hospital	New Hyde	NY	joint		
Blythedale Children's Hospital	Valhalla	NY	spec	X	X
Children's Hospital Medical Center of Akron	Akron	OH	free	X	X
Children's Hospital Medical Center	Cincinnati	OH	free	X	X
Rainbow Babies and Childrens Hospital of the University Hospital of Cleveland	Cleveland	OH	joint	X	
Health Hill Hospital for Children	Cleveland	OH	spec		
Center for Children and Youth Cleveland Clinic Foundation	Cleveland	OH	joint		
Children's Hospital	Columbus	OH	free	X	X
The Children's Medical Center	Dayton	OH	free		
Children's Hospital of Oklahoma	Oklahoma City	OK	joint	X	
Children's Medical Center	Tulsa	OK	spec		
Geisinger Children's Hospital Center	Danville	PA	joint	X	
The Children's Hospital of Philadelphia	Philadelphia	PA	free	X	X
St. Christopher's Hospital for Children	Philadelphia	PA	free	X	X
Children's Hospital of Pittsburgh	Pittsburgh	PA	free	X	X
The Rehabilitation Institute of Pittsburgh	Pittsburgh	PA	spec	X	
Rhode Island Hospital	Providence	RI	joint		
Children's Hospital Medical University of South Carolina	Charleston	SC	joint		
East Tennessee Children's Hospital	Knoxville	TN	free		
Le Bonheur Children's Medical Center, Inc.	Memphis	TN	free	X	X

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Name of Children's Hospital	City	State	Type	Responded to Survey	Included in Finance Analysis
Children's Hospital of Vanderbilt University	Nashville	TN	joint		
Children's Medical Center of Dallas	Dallas	TX	free	X	
Cook-Fort Worth Children's Medical Center	Fort Worth	TX	free	X	X
Texas Children's Hospital	Houston	TX	free	X	
University Children's Hospital at Hermann	Houston	TX	joint		
Santa Rosa Children's Hospital	San Antonio	TX	joint		
Primary Children's Medical Center	Salt Lake City	UT	free	X	X
Children's Medical Center of the University of Virginia	Charlottesville	VA			
Pediatrics Department Fairfax Hospital	Fairfax	VA	joint		
Children's Hospital of The King's Daughters, Inc.	Norfolk	VA	free	X	X
Children's Hospital	Richmond	VA	free	X	X
Children's Hospital and Medical Center	Seattle	WA	free	X	X
Mary Bridge Children's Hospital and Health Center of Multicare Medical Cent	Tacoma	WA	joint		
Children's Hospital of Wisconsin	Milwaukee	WI	free	X	X
Children's Hospital of West Virginia University Hopitals, Inc.	Morgantown	WV	joint	X	

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